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ONTARIO

PROVINCE OF ONTARIO

[Commission and committee enquiries]

THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Park Plaza Hotel,
Toronto, Ontario at 10:00 a.m.
on Wednesday, February 5, 1964.

1964

VOLUME _____ DATE _____

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TORONTO, ONTARIO

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BY THE BOARD OF EVANGELISM AND SOCIAL SERVICE

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Rev. Stewart Givdale
Rev. Gordon Finch
Miss Ethel Chapman
Mrs. Walter A. Riddell
Rev. Harry Martin

THE ONTARIO OSTEOPATHIC ASSOCIATION

Apparances: Dr. D.A. Jadhav
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THE COLLEGE OF PHYSICIANS OF ONTARIO

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VERBATIM REPORTING
SERVICE
TORONTO, ONTARIO

Toronto, Ontario
Wednesday
5th February, 1964

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/AG/rps 1 Crysdale, Assistant Secretary of our Board; the Reverend Gordon

2 ---Upon commencing at 10:00 a.m. from Oak Ridges, Ontario,

3 and there is a reference to this in one of the Appendices;

4 THE CHAIRMAN: Ladies and gentlemen, we will

5 come to order. I presume that the ladies and gentlemen before

6 us here are the members of the delegation from the Board of

7 Evangelism and Social Service of the United Church of Canada.

8 brief, Mr. Cry You have had an opportunity to read the

9 statement of instructions that was given to you by the

10 Secretary. Will the lady or gentleman who is to be your

11 spokesman, please introduce himself and his colleagues?

12 SUBMISSION ON BEHALF OF THE UNITED CHURCH OF Mr. Lord,

13 CANADA

14 BY THE BOARD OF EVANGELISM AND SOCIAL SERVICE

15 Appearances: Rev. J.R. Hord I'm sorry, yes. We believe

16 Rev. Stewart Crysdale

17 Rev. Gordon Winch been elevated that high

18 Miss Ethel Chapman

19 Mrs. Walter A. Ridell

20 Rev. Harry Martin

21 Dr. Hagey, I think I sent you a copy of our

22 REV. HORD: Mr. Chairman, ladies and gentlemen,

23 former brief, which our Church presented to the Royal Commission

24 members of the Committee: To my left is Mrs. Walter A.

25 on Health Services. The Chairman of our Committee Dr. H.C.

26 Ridell. You may remember that Dr. Ridell was a member of the

27 Grant, is an economist; there were some five doctors acting

28 League of Nations back in the thirties when sanctions were

29 on the Committee; able ministers and laymen of our denomination

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Rev. Stewart Crasdale
Rev. Gordon Winch
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Rev. Harry Martin

REV. HORD: Mr. Chairman, ladies and gentlemen,

members of the Committee: To my left is Mrs. Walter A.
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suggested in Ethiopia, and Mackenzie King cut our delegation
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1 Crysedale, Assistant Secretary of our Board; the Reverend Gordon
2 Winch is Council Chairman and is from Oak Ridges, Ontario,
3 and there is a reference to this in one of the Appendices;
4 the Reverend Harry Martin is an Etobicoke minister, of Thistle-
5 town United Church, and we're very happy that he is along to
6 be of reference in his area of his constituency.

7 After I have pointed up certain areas of our
8 brief, Mr. Crysedale would like to add comments. We are
9 actually carrying out a survey in our Church on sociology,
10 so that we have some facts and figures to corroborate the
11 points we wish to make.

12 THE CHAIRMAN: You are the Reverend Mr. Lord,
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2 I wish to mention this to show that we had experts in various
3 fields in the preparation of this document, and also five
4 doctors, and a number of them practising physicians.

5 The Sub-Executive of General Council, the
6 highest court of our Church, has asked the Board of Evangelism
7 and Social Service to adapt and apply this former brief to our
8 Ontario situation.

9 May I give a word of explanation why our Church
10 believes that it should speak out on such important public and
11 social issues as a Medical Insurance Plan. We do not wish to
12 take political sides, we can't do that in the Church, it's
13 not our wish; we do not wish this morning to enter into
14 technical financial problems; experts are trained in this field.
15 As representatives of the Christian Church, however, we believe
16 that we must speak out in defence of people in need, and we
17 believe that this is one of the great areas of need in our
18 modern society, and we make a strong plea that the government
19 of Ontario pass a Medical Services Insurance Act that is
20 directed to meet the needs of those who postpone going to a
21 Doctor because they cannot afford it, and how many people in
22 our society put it off because they can't afford it, or who
23 are faced with crippling doctors', dentists', nurses', and
24 druggist bills.

25 Our Brief points out that there are three areas

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1 of special need among the people of our Province. These are
2 outlined on pages 11 to 14 of our Brief. There are the
3 geographically handicapped, the economically handicapped, and
4 the physically, mentally and emotionally handicapped by reason
5 of accident, age, mental breakdown, and so on.

6 May I say a word about each of these areas of
7 need. First of all -- the geographically handicapped. On
8 page 20, Appendix "A", we have a report confirmed by Mr. J.
9 Firmin, lay supply in charge of our United Church at Horne-
10 payne, Ontario. These facts have been checked by the local
11 doctor at Hornepayne.

12 Now, here we have the situation, at the bottom
13 of the page, the Town of Armstrong with no doctor. Their last
14 doctor left in 1959. At present the nearest doctor is 130
15 miles away. The only communication is by railroad or air
16 and there is no ambulance service.

17 In Hornepayne there is only one practitioner.
18 Seriously ill patients requiring surgery have to go to the
19 Lakehead, 360 miles away.

20 Now, think of the cost of ambulance, and the
21 third last paragraph, stories are told of the impossible
22 situation when patients are seriously ill, the temperature at
23 55° or even more below zero, and the impossibility of their
24 getting proper attention due to the isolation of the community.

25 Now, Mr. Winch has made a statement in Appendix



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1 G, at the last page of the brief, and he might like to say a
2 word from Oak Ridges, Ontario. He makes a special plea that
3 there be more dental inspection and dental care, and this is
4 just a town 20 miles from Toronto, but no doctor or dentist.
5 There should be. Therefore, we would like to ask what provision
6 is there under the proposed Medical Services Act to provide,
7 to relocate hospitals, doctors, dentists, in order to serve
8 the needs of our people who are geographically handicapped?
9 What provision is there for more ambulance service?

10 Mrs. Ridell knows the New Zealand situation,
11 and you might like to ask her a little later for her contribut-
12 ion here.

13 So, that's the first question, is what are
14 we doing to provide more doctors, more services, provide more
15 hospitals, relocate doctors, dentists and nursing services in
16 our geographically handicapped areas.

17 On pages 12 and 13 we point out the economically
18 handicapped. There are hundreds of thousands of families in
19 our society, many of them right here in this city, who are
20 up against it, who have been hurt by life.

21 During this week I have been working on a
22 film, and in that film they show a lady of 87 years of age who
23 lives alone on the top floor of one of these old houses, goes
24 up two flights of stairs without any adequate lighting. She
25 has to carry her water up for all purposes, washing, cooking and



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1 drinking. She has seventy-five dollars a month pension, and
2 forty goes out in rent. She has to have iron shots. She's
3 eighty-seven years of age. In this film the money that was
4 left for food -- they show it the amount of food that that
5 amount of money could purchase, right in front of her on the
6 table, for a month.

7 There are the widows and the widowers; there
2 8 are mothers whose husbands have deserted them, leaving the
9 mother to care for the family; and there are husbands whose
10 wives have deserted them, leaving the children for the husband
11 to care for; there are the unemployed; there are the unskilled;
12 we ministers know about this, because we visit these people.
13 We've been pastors or are pastors.

14 There is no group in society knows the economic
15 situation perhaps more than social workers and clergymen.

16 There are the elderly people languishing in
17 their garrets.

18 May I ask, therefore, is the proposed Ontario
19 Plan geared to help the economically handicapped or is it
20 geared to the profits of the insurance companies?

21 Now, the more that we have studied this Bill,
22 the more disturbed we become, and the more disturbed the people
23 with whom we associate with in society become, and Mr. Crysedale
24 can back this up with a confirmation from a sociological
25 survey, that in the Church, as a Christian church, we believe

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1 that financial policies should be adjusted to meet human need.

2 This is what we are here for as a government,
3 as a church and as a society. We are here to meet and answer
4 human need, but there are indications that the provisions of
5 this proposed Ontario Plan are almost using human need to
6 serve financial ends, and that's of the insurance companies.

7 If it is correct that membership in this Plan
8 might cost an average family \$192, as has been reported, we
9 protest as members of average families that this is too high.
10 We can't afford it. We can't afford it, and this goes for
11 ministers' families too.

12 The position of the United Church of Canada
13 is that the strong should bear the burdens of the weak, and that
14 the wealthy should help to carry the burdens of the financially
15 and economically depressed.

16 This is what we have got wealth for in a
17 country like ours.

18 Now, there are also the physically and emotionally
19 handicapped. I have mentioned the elderly people, and we could
20 take you, on behalf of the Church, to many such families,
21 children born a cripple, the thalidomide baby. There are
22 this type of emergency. This just doesn't happen once in a
23 while. This happens quite often, more of an accidental nature,
24 perhaps, and our governments only accepted responsibility for
25 the thalidomide babies after considerable public pressure was



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1 brought upon them.

2 What about the victims of accidents? What about
3 the increasing number of people who need shock treatments today,
4 who are mentally depressed, and need psychiatric help?

5 Many doctors say that half their patients
6 don't suffer from direct physical causes, but more emotional
7 and mental causes.

8 May I ask, therefore, is this proposed new
9 plan, Bill 163, geared to the help of such physically, chronic-
10 ally and emotionally handicapped people? Is it right, as
11 has been suggested, that it will cost the elderly more to
12 belong to this plan than it will the young and healthy?

13 I was disturbed by Section 18 of the Bill,
14 (1)(a), where they talk about "class-risk". Now, if this
15 means that there is a group in society who have special need,
16 that they would have to pay more, I can't imagine the audacity
17 of a government introducing such a Bill. I can't see how it
18 would meet the public response.

19 Now, I may be wrong in my interpretation here,
20 but this is what I interpret by "class-risk", that they could
21 up the cost for certain high risk people. These are the
22 people we want to help. Will it cost the sick more to enter
23 such a plan?

24 These are the people we're here to help. The
25 position of the United Church of Canada is that a true medical



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1 health plan should, for reasonable rates, provide for the
2 medical, dental, surgical needs of all people who are afflicted
3 because of disease, accident, senility or mental breakdown.

4 Now, I have just one other matter, perhaps two other things,
5 I will refer to, and then I will ask my colleagues to refer
6 to this.

7 We have the health education of the public,
8 and the prevention of illness. We know that an ounce of
9 prevention is worth a pound of cure, and much less costly.
10 Will the proposed Ontario Plan provide for regular medical
11 and dental checkups?

12 This is the greatest prevention we can have,
13 this great service which we believe that such a Bill should
14 have.

15 We should also like to protest the means test.
16 I think we are all very strongly -- I know Miss Chapman has
17 spoken very strongly on this.

18 The Reverend Robert Wright, on page 31, sub-
19 section (2), has commented on the means test, at the bottom
20 of the page, he says, the person on welfare usually ends up
21 a degraded human being who takes full advantage of everything
22 he can in the way of free services. It permits exploitation
23 by those who have never had scruples, while others are too
24 proud to come for help until it is too late.

25 Now, we feel that a means test would only add to

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1 this group in society, who will take all they will get. They
2 have to take all they will get because their independence has
3 been broken, their pride has been broken, they are pushed to
4 the wall. They will take all they can get.

5 Now, certainly we should not foster this
6 type of attitude, and we shouldn't add to this group within
7 our society. We must protest most strongly the means test.
8 The average Canadian citizen is an independent person who
9 resents being considered an object of charity, and no self-
10 respectful citizen has the right to ask anyone to become an
11 object of charity in our type of society.

12 May I just refer to the Resolutions passed by
13 the General Council of the United Church of Canada, on pages
14 4 and 5. This goes back to 1952, where we took a strong
15 stand for a comprehensive national medical health plan. This
16 was confirmed again at the Sixteenth General Council, in 1954,
317 and very strongly supported in 1960.

18 At the bottom of the page, Section (c):

19 "The Nineteenth General Council, Edmonton,
20 Alberta, September 1960:

21 "Whereas the cost of medical care and
22 treatment is a heavy burden which many are unable
23 to bear; and

24 "Whereas there are those who are deterred
25 from seeking medical care and treatment because



1 of the high cost involved; and

2 "Whereas existing medical insurance
3 plans are inadequate to cover all medical needs;
4 and

5 "Whereas the Sixteenth General Council
6 has endorsed 'an integrated and contributory
7 national health insurance program':

8 "IT IS RECOMMENDED THAT THIS GENERAL
9 COUNCIL:

10 "(1) Re-endorse the principle of a
11 National Health Insurance Plan.

12 (2) Commend the Province of Saskatchewan
13 for steps being taken to implement
14 such a program on the provincial level;
15 and

16 (3) Urge the Federal government in co-op-
17 eration with the medical, dental, nursing,
18 pharmaceutical and related professions
19 to establish a comprehensive national
20 health insurance program."

21 Now, I've just pointed up certain emphases in
22 our brief, and tried to make them more applicable, more pointed
23 to our Ontario situation, and I know that my colleague, Mr.
24 Crysedale, is prepared to back this up with more facts and
25 figures, and I know that my other colleagues feel very strongly



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"(1) Re-endorse the principle of a

National Health Insurance Plan;

(2) Command the Province of Saskatchewan

for steps being taken to implement

such a program on the provincial level;

and

(3) Urge the Federal government in co-op-

eration with the medical, dental, nursing

pharmaceutical and related professions

to establish a comprehensive national

health insurance program."

Now, I've just pointed up certain emphases in

our brief, and tried to make them more applicable, more pointed

to our Ontario situation, and I know that my colleague, Mr.

Crysdale, is prepared to back this up with more facts and



1 in this matter.

PB/rsp 2 THE CHAIRMAN: May I make one comment: many
3 of the statements that you made were made in the form of a
4 question and particularly, specifically will these things be
5 included in this Bill. I presume, even though it is stated
6 as a question you don't expect an answer from this group at
7 this time because we haven't yet made our recommendations.
8 We don't know exactly what the Bill will be. We don't even
9 know what we will be recommending.

10 REV. HORD: The questions on the proposed Bill
11 were meant as rhetorical questions to draw up what we regard
12 are glaring weaknesses in this proposed new Bill, what seem
13 to be holes in it to us.

14 REV. CRYSDALE: I have a few comments on Bill
15 163 which are intended to clarify and support the submission
16 of the United Church of Canada as presented by my colleague,
17 Mr. Hord.

18 First, we have recent evidence that the members
19 and adherents of the United Church in Ontario solidly support
20 the contention of the General Council that a medical insurance
21 plan should be universal, comprehensive and contributory.
22 Sometimes it is said that church boards pass resolutions without
23 putting them to the members. We are conscious of this
24 possibility. Therefore our Association of the United Church
25 attempted to discover what our people in various sections and



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First, we have recent evidence that the members

and adherents of the United Church in Ontario solidly support the contention of the General Council that a medical insurance plan should be universal, comprehensive and contributory.

Sometimes it is said that church boards pass resolutions without putting them to the members. We are conscious of this possibility. Therefore our Association of the United Church attempted to discover what our people in various sections and



1 walks of life believe and practise. The returns are not yet
2 complete on the study we are conducting, but we have sufficient
3 returns from the people of Ontario who are affiliated with
4 our Church to learn they are solidly behind the contention of
5 the General Council in this respect. Furthermore the question
6 that they were asked to answer indicated, the replies to
7 this question indicated that such a plan should be government-
8 operated and tax supported. Neither of these points have
9 been raised in the official brief which has been presented
10 earlier this morning.

11 Returns to date show that 67% of members and
12 adherents in Ontario favour a plan having these characteristics.
13 One might say it is not an overwhelming majority but the
14 proportion were 67% in favour, 16% definitely negative and
15 17% not certain. I am not a betting man but the odds were
16 fairly good, two to one now or five to one if those who are
17 uncommitted at the moment should favour it.

18 By direct inference, Mr. Chairman, the United
19 Church rejects the limited coverage proposed in Bill 163.

20 Secondly, we stress the fact that the need
21 for a universal, comprehensive and tax-supported medical care
22 plan is becoming increasingly and critically urgent. Thousands
23 of workers are retiring earlier, for the most part involuntarily,
24 due to obsolescence of their skills and trades in our rapidly
25 changing technological society. The trend toward automation



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1 and concentration in merchandising and service industries is
2 steadily reducing the opportunities for self-employment which
3 formerly served to augment the shrinking income of older
4 workers. A few years ago, displaced farm and factory workers
5 often could find work in stores, laundries, construction and
6 other unskilled labouring jobs. These openings are shrinking
7 rapidly in relation to the increasing labour force.

8 We are also told by analysts that the teenage
9 component of the labour force will double by 1970. Already un-
10 employment among youths aged 16-24 is twice as great as the
11 rate in general. The heavy burden of supporting these unemployed
12 youth rests for the most part upon working class families at the
13 very time when family allowances and insurance coverage under
14 contract and voluntary plans run out.

15 The economic and social prospects for working
16 class families, and those are the ones for whom we are most
17 concerned this morning, are further diminished by the continuing
18 movement of population to metropolitan areas. We have a vicious
19 circle of shrinking employment in rural areas and a drift of
20 people to the cities, where unskilled men get low-paying jobs
21 and women and girls get temporary, part-time, low-paid work.
22 This multiply-employed factor in labouring families, working
23 class families enables them to live.

24 The family farm and intimate rural community
25 once provided a small measure of economic and social security.

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1 There was always an extra place or two at someone's table.
2 This kind of informal, communal assistance is not available to
3 the working class family in metropolitan society. White collar
4 as well as blue collar workers are terribly vulnerable to
5 market changes, short and long range.

6 Mr. Chairman, some of us have devoted many
7 years to the service of lower middle-class and so-called
8 lower-class families in both country and city. I myself have
9 been privileged to serve them in the church for twenty years.
10 I have also been moved by such trends as I have briefly
11 described to make urban society the subject of careful
12 academic study.

13 I am convinced, and my Church is convinced,
14 that the provisions for medical services proposed in Bill 163
15 are totally inadequate to meet the needs of modern industrial
16 society. I would suggest, without being facetious this is
17 "horse and buggy" legislation for an urgent space-age need.

18 Adequate provision for health services in a
19 country with the high overall standard of living Canadians
20 enjoy must take account of the wide discrepancies that
21 exist in size of income and conditions of health. We are
22 gratified Mr. Chairman that this problem is recognized by the
23 Government in the introduction of this Bill. We would maintain
24 that the bill's methods of meeting the problem are unacceptable.

25 Our specific objections, briefly, are three-



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1 fold. First, the proposed means of spreading the risk still
2 excludes the growing multitudes of poor but self-supporting
3 families -- I would underline self-supporting families in both
4 country and city. Its voluntary nature and high cost rule
5 them out, or tend to rule them out.

6 Second, our objection to an extension of the
7 means test to include many marginal people is morally and
8 socially unsound and in fact reprehensible. Most working
9 people are precariously holding on to the shreds of independ-
10 ence that still remain to them in our mechanized, mass society.
11 They are doing so with a wholesome determination and pride
12 that should be encouraged by government. I take it this is
13 the overall intent of our government. A higher proportion
14 of working class families own their homes, or are buying them
15 (at high financing costs), than middle and upper class
16 people. To require of large numbers of them in times of
17 prolonged illness the sacrifice of their homes and other
18 small independencies in exchange for health services is
19 both unjust and economically and socially unsound. When the
20 lower middle-class are deprived of their hard-won independence,
21 freedom and democracy quickly crumble.

22 The question of the degree of poverty and the
23 extent of need for subsidized health services without a means
24 test should be carefully assessed, Mr. Chairman. We have
25 statistics of unemployment and indigence, and these tell



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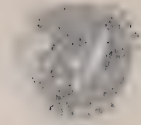


1 a depressing story of massive want in the midst of plenty.

2 Bill 163 would help many of these unfortunate
3 people, it is true, but there is much greater burden of poverty
4 or near-indigence that is not revealed in readily available
5 statistics. It is estimated that one-fifth of the population
6 of the United States are denied the minimal levels of health,
7 housing, food and education, which are indicated by our
8 scientific age, in spite of the highest over-all standard
9 of living in the world. We do not have firm figures for
10 Canada or Ontario, although steps are now being taken by the
11 Canadian Welfare Association to obtain such figures. It may
12 be asserted, however, on the grounds of empirical observation
13 by church and social workers, that the degree of poverty and
14 need of public health services should shock and disturb tax-
15 payers and law-makers alike.

16 Our third specific objection is to the restrict-
17 ive nature of the services to be insured under Bill 163.
18 We are grateful for hospital insurance, and, heaven knows,
19 we need insurance to meet physicians' and surgeons' bills.
20 But the high cost of drugs, dental care and other health needs
21 impoverish thousands of marginal families. These services
22 must be included in an equitable plan. If you desire, sir,
23 these observations can be substantiated by thousands of case
24 studies in the files of church and social workers.

25 Now, Mr. Chairman, I come to my last point,



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1 a crucial one it seems to me. It may seem to acturial minds
2 on your committee, and your committee, our committee and in
3 our Church boards and in the seats of the treasury, that we are
4 asking for the moon. The Church, the labour movement and
5 social workers are accustomed to the objection that it will
6 cost too much. This is a realistic question and it needs to
7 be faced. This was the sad story when we pressed for Workmens'
8 Compensation, mothers' and widows' allowance, unemployment
9 insurance, old age pensions, maximum hours of work, minimum
10 rates of pay, industrial standards, bargaining rights, holidays
11 with pay, and other progressive social legislation. I am
12 sure it was the same when our forefathers demanded a public
13 postal service and "free" universal education. But it is a
14 matter of record in economic history, with this I think we
15 find little argument to the contrary, that high wages and
16 social security contribute importantly to social stability,
17 progress and general prosperity.

18 Some complain still that what we ask for
19 will cost the public too much. No one knows better than a
20 clergyman the immense and tragic cost of sickness in a
21 society where preventive care is neglected. The fact is that
22 the least able to pay are carrying the heaviest share of
23 the burden. You well know, sir, that broad insurance
24 coverage will not increase the total social cost, but distribute
25 it equitably through society. It is the basic humanitarian



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1 principle, Mr. Chairman, that we find is insufficiently served
2 in Bill 163.

3 Your Commission might enquire into the costs
4 and benefits of universal, comprehensive medicare plans which
5 have existed in many civilized countries for years. There is
6 little evidence that the cost has crippled the competitive
7 power or endangered the basic freedoms of such countries as
8 Great Britain, the Scandinavian countries, Australia, New
9 Zealand and other countries which share our basic outlook on
10 life.

11 Ontario as a whole can, sir, well afford a
12 universal, comprehensive, contributory health insurance plan.
13 She has pioneered in other progressive social legislation.
14 Let not the vested interests of a few companies hinder this
15 province from sound and statesmanlike legislation in this
16 matter of fundamental public interest. The public is not
17 forever deceived. The basic principle at question, Mr.
18 Chairman, is really not total cost, but public as against pri-
19 vate administration of the measures required to meet the
20 common man's need for adequate medical and health care. It
21 is plainly too much to expect private insurance firms alone to
22 undertake such a vast and unprofitable scheme. It is within
23 the capacity of government alone to do so, in co-operation,
24 of course, with the health professions and concerned private
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1 would maintain this is the duty of government in a society
2 dedicated to the welfare of all its citizens.

3 Thank you, Mr. Chairman.

4 THE CHAIRMAN: Does Mrs. Ridell wish to make
5 her comments now?

6 MRS. RIDELL: Thank you very much. This is
7 not in the brief except a reference to New Zealand. I would
8 like to suggest very respectfully that perhaps the Commission
9 might, and I know that they already know what is in force
10 in New Zealand, but it seems to me it is a very sound
11 principle because I think we are all very much concerned with
12 the idea of people getting something for nothing. In the
13 New Zealand scheme everybody pays according to their income.
14 I mean, there is a certain amount deducted. The unemployed,
15 don't, of course come under that. Everybody pays according
16 to their own income, what they actually earn. Therefore that
17 is a comprehensive medical insurance plan. It operates not
18 only medically and in hospitals but drugs, which, I feel in
19 Canada are absolutely prohibitive for the lower income group
20 because very often they can go to a doctor, they may be
21 covered, they may get the service there but the cost of
22 the prescription that the doctor has given them is often
23 absolutely prohibitive for them to get and so they don't take
24 it and the whole thing is really wasted; whereas in New
25 Zealand with the scheme that they have there, Mr. Chairman, each



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1 person pays according to their income and it means that the
2 lower income people pay very little and the people that can
3 afford pay a great deal more. It is comprehensive. It makes
4 a tremendous difference. People will go knowing that they
5 have paid for it and they are not accepting charity. They
6 will go and get medical help at the beginning and it costs
7 so much less and often prevents a prolonged illness.

8 With the prohibitive costs they go there and
9 they can do that. Also both governments, both local and
10 national governments in New Zealand have accepted their share.
11 It has been in force for years as in the other countries,
12 the Scandinavian countries and Great Britain. I just humbly
13 suggest, sir, that I think the New Zealand scheme is one of
14 the very best that they have. It is comprehensive. Everybody
15 pays according to their needs. It helps the doctors to a
16 great extent in that they don't have bad debts, they don't
17 have bookkeeping things and they don't do charity work because
18 they are paid on a fee basis.

19 THE CHAIRMAN: I understand New Zealand has
20 a rather refined climate at the present time of year?

21 MRS. RIDELL: Of course it is their summer.

22 THE CHAIRMAN: I thought possibly you were
23 going to suggest that members of the Enquiry might visit
24 New Zealand.

25 MRS. RIDELL: I think it would be a very good

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1 idea. It is a wonderful country. They are wonderful people
2 there. I think Canada could learn a little bit on the racial
3 question the way the Maoris are treated there in comparison
4 to what we are doing over here.

5 THE CHAIRMAN: Are there any further comments?
6 I know many of the members of the Enquiry have questions to
7 ask you.

8 /rps REV. HORD: Miss Chapman might like to make
9 that comment.

10 MISS CHAPMAN: I think perhaps the most
11 important points have been covered. The people I have
12 closest contact with are, of course, the rural people across
13 the country -- farmers, village people, and so on. I know
14 they might not be considered economically handicapped. In
15 self-defence they have set up their own co-operative medical
16 plan.

17 Another thing that I was interested in, in
18 your discussion, was the hope of what this may develop in
19 preventive medicine.

20 Universal coverage was that a doctor never
21 needed to feel he is drumming up business if he went out of
22 his way to want to keep people well. We could carry on to
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1 known -- it has nothing to do with any church, but the women's
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3 health units in immunization clinics and pre-school clinics.
4 The nurses from the County Health Units come out to talk to
5 them and sometimes doctors.

6 If we could have that feeling of close co-oper-
7 ation that we have in preventive medicine in health units
8 with our family doctors and the standard of health we could
9 build up here, is something that we have not begun to realize
10 yet.

11 REV. HORD: Rev. Winch would like to say
12 a word.

13 REV. WINCH: Anything I would say would be
14 in terms of specific instances. Not having served in a
15 community that is a depressed community in many ways in the
16 past nine years, my mind races from one family situation to
17 another where lack of medical services and high costs have
18 created definite hardships.

19 I would just say this one thing, that we have
20 used the word, particularly in Mr. Crysdale's presentation,
21 "charity" as opposed to individual family circumstances,
22 a family that gets to the point of being on welfare.

23 I have just come to realize the full horror
24 of this and this is the only way I can describe it. Once
25 a family loses that spark of independence, that feeling that



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of this and this is the only way I can describe it. Once
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1 it can and must pay its own way, a very great tragedy ensues.

2 I regard this problem so deeply, I discovered.

3 It is in the best wisdom of our church not
4 to give anything, where we can avoid it, to our own members
5 even when in great hardship. Partly because this closes the
6 door to us. If our families need something specifically,
7 I would go to the Lion's or Township for help for them. For
8 us to go to them directly, this sort of cuts through their
9 dignity and pride. I have seen the same thing in relationship
10 to the inability to pay for medical services that they needed
11 and wanted for themselves and for their children. It has
12 just, at this point, struck me forcefully that somehow we
13 must for the benefit of the people determine those who could
14 be pushed over to a category of welfare and charity and those
15 who cannot yet be pushed over.

16 My next door neighbour is a woman, a widow
17 with a retarded child. That child requires \$30 a month for
18 medical attention. She works at housecleaning for between
19 80¢ an hour and \$1.00 an hour. This is an enormous hardship.
20 They live in a real shack. I am not sure that I could stand
21 to live in the sort of house they live in.

22 I could multiply the instances ten-fold because
23 I see them every day where lack of basic financial ability to
24 pay reaps a real hardship. Yet, people want to retain the
25 status of independence and self-reliance.

it can and must pay its own way, a very great tragedy ensues. I regard this problem so deeply, I discovered.

It is in the best wisdom of our church not to give anything, where we can avoid it, to our own members even when in great hardship. Partly because this closes the door to us. If our families need something specifically, I would go to the Lions or Township for help for them. For us to go to them directly, this sort of cuts through their dignity and pride. I have seen the same thing in relationship to the inability to pay for medical services that they needed and wanted for themselves and for their children. It has just, at this point, struck me forcefully that somehow we must for the benefit of the people determine those who could be pushed over to a category of welfare and charity and those who cannot yet be pushed over.

My next door neighbor is a woman, a widow with a retarded child. That child requires \$30 a month for medical attention. She works at housecleaning for between 80¢ an hour and \$1.00 an hour. This is an enormous hardship. They live in a real shack. I am not sure that I could stand to live in the sort of house they live in. I could multiply the instances ten-fold because I see them every day where lack of basic financial ability to pay keeps a real hardship. Yet people want to retain the status of independence and self-reliance.



1 I could agree wholeheartedly with Mr. Crysdale
2 that this is basic to our democratic and free way of life.

3 REV. MARTIN: I have nothing new to add except
4 that I feel in essential agreement with Mr. Crysdale's comments.

5 I have one illustration that I might leave
6 with you. I live and work in an area not regarded as a needy
7 one. They are average people. But, I have a near neighbour,
8 a working man who has struggled and built his home and maintained
9 his home. He did pay out about \$700 to an orthodontist and
10 was very glad to be able to pay it and that he was able to
11 have the work done for his boy. I do have a feeling that
12 I should be helping that man, and lots of neighbours feel the
13 same. He has a particular misfortune and a particular need
14 and that I, who has not had that same need, it has not struck
15 me -- but I thought I should be helping him pay that through
16 taxation and through a general broad scheme and he would not
17 be made to feel an object of charity and not made to bear
18 a heavy burden which he is ill-equipped to bear.

19 THE CHAIRMAN: There will be other questions
20 directed to you and if you wish you may have your colleagues
21 answer them.

22 MRS. AYLEN: In your brief you speak of
23 "geographically handicapped". Some of these are in the far
24 north and also a district closer to the City of Toronto.

25 Do you feel on your Bill 163 if the physicians'

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with you. I live and work in an area not regarded as a needy

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"geographically handicapped". Some of these are in the lar-

gely and also a district closer to the City of Toronto.

Do you feel on your Bill 168 if the physicians



1 fees were paid that this would alleviate this shortage?

2 REV. HORD: The specific point I brought out
3 of these geographically handicapped areas is that we should
4 have a plan where there is some relocation of doctors and
5 nurses and hospitals.

6 MRS. AYLEN: Who should be responsible for
7 relocating?

8 REV. HORD: The Department of Health. They
9 should have a government plan in order to serve the remote
10 areas.

11 MR. CASWELL: You just tell a doctor where he
12 is assigned to?

13 REV. MARTIN: My ministry started in Saskatchewan
14 nearly 20 years ago. At that time there were certain
15 inducements, I think, offered -- financial inducements so we
16 would have doctors in remote and distant areas. This is long
17 before the government plan. We had a municipal doctor, we
18 had a doctor in our municipality. He was certainly not told
19 to go there or made to stay. But, the financial rewards were
20 considerable. I think, more than other areas, And we did have
21 doctors in those areas because the income was so good. I
22 do not know whether this is a partial answer, that some subsidies
23 could be offered.

24 THE CHAIRMAN: I gather you have not discussed
25 this far enough within the church, so as a church you are prepared

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THE CHAIRMAN: I gather you have not discussed

this far enough within the church, so as a church you are prepared



1 to make a specific recommendation of how this is to be
2 achieved. You are recommending this condition should be
3 corrected.

4 REV. HORD: We have studied the United Kingdom
5 scheme and the Saskatchewan scheme.

6 Mrs. Ridell has spoken on the New Zealand scheme.

7 Miss Chapman might have a further comment here.
8 She is well versed in this field.

9 MISS CHAPMAN: I am not very clear on this.
10 Doesn't the Ontario Government give bursary to medical
11 students who undertake to practise in rural areas after
12 graduation?

13 DR. BUTT: I think it was brought out this
14 past year. There are now students at school who have this
15 obligation to go to a specific area. Where they are supposed
16 to go have not been stated in any detail, but that is already
17 clear. Is this what you had in mind?

18 REV. HORD: Yes. I think someone has to take
19 leadership.

20 DR. BUTT: This is a bursary for a specific
21 purpose. It does not have anything to do with the Department
22 of Health.

23 REV. HORD: Mr. Crysdale might have a comment.

24 REV. CRYSDALE: I think we, as a church, would
25 not presume to supply a solution for this problem. We have our

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REV. GRYSMAN: I think we, as a group, would

not presume to supply a solution for this problem. We have our



1 individual notions. It has been made the subject of careful
2 study, as you have suggested.

3 I think I would like to re-assure the members
4 of the Committee that we would be just as much concerned with
5 the system of medicine as we are for our own profession and
6 that corrected measures to meet the structural changes of our
7 new society need to be carefully worked out in full relation-
8 ship to medical and other health professions. There is no
9 suggestion of perversion in our request that the matter be
10 studied and secondary attention given and a financial provision
11 be made to offset some of the inequities that have come about
12 as changes to our social structure.

13 REV. HORD: Mr. Winch mentioned Oak Ridges where
14 a doctor and dentist has not come in because they are lower
15 income people and there would not perhaps be enough returns
16 there. If adequate income was assured, I am certain there
17 are many doctors, younger doctors, who would serve at least
18 a few years in that type of area. It would not be compulsion.
19 Doctors are here to serve human needs the same as the rest of
20 us are. But, they also need an income because of their
21 business.

22 MRS. AYLEN: On page 13 you state here:

23 "We have been unable to establish infirmary
24 care in conjunction with our Senior Citizens
25 Homes ---"



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MR. WINCH: On page 13 you state here:

"We have been unable to establish infirmaries

and in connection with our Senior Citizens

Home."



1 How did you attempt to establish this care --
2 on a group basis or is each patient allowed to have his own
3 doctor?

4 REV. HORD: The situation we find in the
5 United Church is, for many years we have had home mission
6 hospitals out in areas with the increasing complexity and
7 cost of medical services and hospital equipment, X-rays and
8 so on. There is just not enough funds through the missionary
9 monies to pour into these hospitals. So, our General Council
10 has suggested we keep out of this field.

11 Now, in recent years we have had this great
12 need for elderly citizens' homes. We have built some 22 of
13 them across the country with some 1,200 residents subsidized
14 by government, by giving of grants from the government. The
15 very urgent need in our homes is that we have a wing for
16 nursing care and we have another wing for more serious cases,
17 an infirmary.

18 MRS. AYLEN: I understood from your remark that
19 you could not get medical care.

20 REV. HORD: No. We cannot afford it. This is
21 the chief reason.

22 MRS. AYLEN: Can the patients not pay the
23 doctors for their medical care?

24 REV. HORD: No, they have to leave the home
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1 MRS. AYLEN: The medical profession won't go
2 to the homes?

3 REV. HORD: We cannot set up an infirmary.
4 Once you set up an infirmary you have to have the equipment
5 and the doctor has to have everything that is needed. So,
6 we only have one infirmary in Montreal. This is set up just
7 like a hospital, but it is very expensive.

8 MRS. AYLEN: On page 23 at the very bottom of
9 the page you say:

10 "The new out-patient treatment, he believes,
11 "will be a very practical help to the working
12 "man and his family."

13 Where does this occur, this new out-patient
14 treatment?

15 REV. HORD: I am sorry that Mr. Di Stasi is not
16 with us. I think this is in conjunction with our hospitals.

17 MRS. AYLEN: You mean in Toronto?

18 REV. HORD: Yes. Like Western Hospital and
19 so on. Perhaps Dr. Butt might help us here. I know from
20 visiting the hospitals, we see there the active out-patient
21 clinic.

22 MRS. AYLEN: I want to clarify that "new
23 out-patient treatment". They have had out-patient clinics
24 operating for a very long time, and I want to know what you
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1 pilot scheme?

2 REV. HORD: It might be.

3 THE CHAIRMAN: Dr. Butt?

4 DR. BUTT: I have enjoyed this very much being
5 a member of the United Church.

6 REV. HORD: Are you from Newfoundland?

7 DR. BUTT: No. I am not from Newfoundland.

8 However, I would like to ask Mrs. Ridell who
9 very specifically mentioned the New Zealand scheme and it
10 is associated with the Australia scheme, is that correct?

11 MRS. RIDELL: The two schemes are a little
12 different.

13 DR. BUTT: Would you be good enough to continue
14 in detail the Australian scheme for us. I think it is a
15 comparable country relative to population and area. Perhaps
16 some of the problems they have already looked after, and
17 this would be of value to us.

18 MRS. RIDELL: The Australia scheme varies a
19 bit.

20 In New Zealand it is based on the earning
21 capacity of the person, whereas in Australia there is a definite
22 amount that is not based on so much of the earning capacity.
23 It is not taken from the income. There is a stated amount
24 that each person pays towards it, also based on income but
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that each person pays towards it, also based on income but

not to the same extent.



1 DR.BUTT: Could you give us the mechanics?

2 Do they pay the doctor directly?

3 MRS. RIDELL: In New Zealand, no they do not
4 pay the doctor directly. They can if they wish. What they
5 do there is, the doctor puts in --- The doctor is allowed so
6 much a visit. The doctor has the privilege that if some
7 people have a little more money he can make a general agreement---

8 DR. BUTT: In Australia, as I understand it,
9 the patient does not ---

10 MRS. RIDELL: --- and is reimbursed by the
11 government.

12 DR. BUTT: Is this also true in New Zealand?

13 MRS. RIDELL: It can be either. The doctor
14 can get it from the government. It is a very satisfactory
15 arrangement, Dr. Butt, because they feel it does away with
16 a great deal of bookkeeping.

17 DR. BUTT: It also maintains their independence.

18 MRS. RIDELL: And keeps their independence.

19 DR. BUTT: The reason I want to bring this
20 out is to have the views of somebody who has lived with it
21 and think it is comparable in many ways. It is something
22 we probably should consider as opposed to some of the other
23 types.

24 MRS. RIDELL: New Zealand has not the population
25 that Canada has.

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1 DR. BUTT: But Australia has.

2 MRS. RIDELL: Australia has. They have found
3 it very very satisfactory on this whole question of getting
4 the whole thing in.

5 DR. BUTT: Thank you. There are a number of
6 little things with regard to dispensing of charity. I know
7 these are words from the church and they are certainly things
8 we think about. Do you think that charity as a word is a
9 bad thing? Now this is what seems to be brought out by some
10 of the statements as I heard them.

11 REV. CRYSDALE: Thank you for this opportunity
12 to clarify our views on charity. Charity is derived from
13 the Greek word charis which is frequently also translated as
14 love. Therefore to both the Hebrew and the Christian tradition
15 charity is a very honourable word.

16 DR. BUTT: This is the paradox in which I
17 find myself: having listened to many of these things for
18 many many years from my uncle and in the church, I just don't
19 know what is brought out here.

20 REV. CRYSDALE: Mr. Chairman, the point here
21 is that the practice of charity as a society is a highly
22 commendable thing, but where it becomes a profession and a
23 way of life, as it has here, a very serious question as to
24 substantiation from the Christian or Hebrew attitude.

25 THE CHAIRMAN: Was your point not this is an

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substantiation from the Christian or Hebrew attitude.

THE CHAIRMAN: Was your point not this is an



1 argument for it?

2 REV. CRYSDALE: I would like to clarify our
3 point. We may have overstressed a point that many people on
4 charity are by no means unworthy of that charity. I think we
5 would wish to insist upon this, and clarify this point. The
6 submission is that we should not make charity the only choice
7 which a person has by reason of their economic circumstances
8 and conditions of health.

9 Therefore, the way you would construe charity
10 today as a Church, the provision, in our whole social way of
11 life, of the right to certain minimum standards of life. This
12 was provided for in Christendom in the mediaeval days through
13 the work of monasteries. Today, the Church no longer has
14 access to income from lands and other sources, fixed income
15 and is unable to finance a broad scheme of charity to the
16 deserving poor and this has become a function of government
17 in our modern society and we would not like it to be construed
18 that we are in any way denegrating the Greek term charity.

19 It is simply that we wish that there should be
20 separated from charity as a broad concept of social justice
21 the idea that they are second-rate citizens who, because they
22 can no longer afford a minimal standard of life and independence
23 are therefore compelled to a way of life which we deeply
24 deplore.

25 THE CHAIRMAN: Thank you.

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THE CHAIRMAN: Thank you.



1 DR. BUTT: I think that has probably cleared
2 it up in my mind. I may say your final paragraph on page 5,
3 I am in complete agreement with. Certainly it is hoped that
4 all these combinations will be looked into and brought
5 together. This is certainly our objective, with all your
6 criticisms, and I take them advisedly, and we have brought
7 and thought of a good deal of other things that come into it.
8 For instance, another question that bothered me, you say on
9 page 11 of your brief:

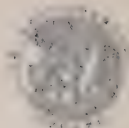
10 "Provision should be made for night
11 "calls, supply during doctors' holidays and
12 "emergency situations."

13 And so on. I wonder if you found, by any chance,
14 hospitals and so on during weekends and holidays more and more
15 are becoming difficult to carry on normally or do you think
16 medicine should carry on seven days a week? We are having
17 problems on that. Doctors are willing to work. I just
18 wondered if you had any suggestions?

19 REV. HORD: My only reaction is in every decent
20 sized town there should be a hospital and perhaps a couple of
21 doctors so there would always be one doctor around. Of course,
22 in the north, you get one doctor. He has got to go on holidays.
23 This is true. It's very difficult for him to get someone, but
24 we would hope perhaps there could be somebody there.

25 DR. BUTT: Then you make several statements with

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DR. BUTT: Then you make several statements with



1 regard to the dental service and you feel they should be
2 increased, and so on. Well it is not really in the terms of
3 reference of this particular Bill at the moment, but certainly
4 it is within our consideration. Do you feel a supply of
5 these, or do you think if you merely allocated them then you
6 would have all the dental care taken care of?

7 REV. HORD: Mr. Winch might like to comment
8 from his own community on it. I notice he brought this up.

9 REV. WINCH: My comment Mr. Chairman, and Dr.
10 Butt, is that this is one of the last things that people sort
11 of on the marginal scale of living pay for or seek and in
12 our community, one part of our community particularly, a ten-
13 room school and I think it would break the heart of any
14 respectable dentist to stand outside that school and watch
15 the children come out, from the point of view of their teeth.
16 It is terrible and these people are first: five miles from
17 the nearest dentist.

18 DR. BUTT: This is in which area?

19 DR. WINCH: Oak Ridge, just a few miles outside
20 of Toronto. 20 miles from Toronto. We have, as I point out
21 in this Appendix G, no medical or dental service on a full-time
22 basis in our community. Strictly a matter of making an
23 appointment, going out of the community. Now it is only a
24 few miles and it is possible many of our people do have cars,
25 but it isn't done. Partly it is not available in terms of an

regard to the dental service and you feel they should be increased, and so on. Well it is not really in the terms of reference of this particular Bill at the moment, but certainly it is within our consideration. Do you feel a supply of these, or do you think if you merely allocated them then you would have all the dental care taken care of?

MR. WING: Mr. Wing might like to comment

from his own community on it. I notice he brought this up.

MR. WING: My comment Mr. Chairman, and Dr.

Butt, is that this is one of the last things that people sort

of on the marginal scale of living pay for or seek and in

our community, one part of our community particularly a ten-

room school and I think it would break the heart of any

respectable dentist to stand outside that school and watch

the children come out from the point of view of their health.

It is terrible and these people are first: five miles from

the nearest dentist.

MR. WING: Our riding, just a few miles outside

of Toronto, 20 miles from Toronto. We have, as I point out

in this Appendix G, no medical or dental service on a full-time

basis in our community. Statistically a matter of making an

appointment, going out of the community. Now it is only a

few miles and it is possible many of our people do have cars,

but it isn't done. Partly it is not available in terms of an



1 educated persuasion. I think a lot of people who live in a
2 marginal level need to be told that this should be done early,
3 while they can still save their children's teeth.

4 THE CHAIRMAN: Does your memorandum on this
5 speak about population?

6 REV. WINCH: Between four and five thousand
7 sir.

8 REV. HORD: Page 34 Dr. Hagey.

9 REV. WINCH: I would say, Mr. Chairman, if I
10 may be permitted, in a comparable community -- we are on
11 Yonge Street -- in a comparable community along Yonge Street
12 there may be as many as ten doctors serving.

13 THE CHAIRMAN: Mr. Caswell?

14 MR. CASWELL: Mr. Chairman, Reverend Hord,
15 I suppose you are aware of the fact that your brief is sub-
16 stantiating many briefs we have received which are concerned
17 with a very comprehensive care situation and this is certainly
18 making a job of this Committee a more and more difficult one
19 because we also recognize the great need yet we don't know
20 just how to handle it.

21 I was interested in the fact the church has
22 made a survey of its members to support the General Council's
23 views. Is this a recent survey and was it made in rural
24 churches as well as in cities?

25 DR. HORD: Reverend Crysdale has just carried



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1 this out for us. By the way, Mr. Crysdale has studied for many
2 years, taken courses at our own school here, and in New York,
3 has just spent a year at Berkeley California; has now been
4 employed by the Church emphasizing this special approach.

5 REV. CRYSDALE: I would still not wish the
6 Commission to think of me as an expert in this field, but
7 in reply to the question: The study we are now conducting
8 is a national survey which will include roughly two thousand
9 cases in the sample which will represent fully in proportion
10 the rural population as well as the urban population.

11 MR. CASWELL: Two thousand churches you mean?

12 REV. CRYSDALE: Two thousand cases sir in the
13 sample. This is considered to be individual cases and about
14 250 congregations which are carefully chosen both at random
15 and systematic method to reach the entire constituency of
16 the church.

17 MR. CASWELL: I don't question what the answer
18 will be Mr. Crysdale. I am just wondering why it was
19 confined. Perhaps this is because of the mechanics available
20 to your organization to take a survey. No doubt whether it
21 is larger or smaller the people would answer in the affirm-
22 ative. I was just interested to know if it was on a wide
23 scale, and if so why I did not become acquainted with this
24 before.

25 REV. CRYSDALE: In further reply sir, the sample



by the way, Mr. Grysbale has studied for many years, taken courses at our own school here, and in New York, has just spent a year at Berkeley California, has now been employed by the Church emphasizing this special approach.

REV. GRYSBALE: I would still not wish the Commission to think of me as an expert in this field, but in reply to the question: The study we are now conducting is a national survey which will include roughly two thousand cases in the sample which will represent fairly in proportion the rural population as well as the urban population.

MR. CASWELL: Two thousand cases, you mean?

REV. GRYSBALE: Two thousand cases are in the sample. This is considered to be a fairly good case and about 250 congregations which are carefully chosen both at random and systematic method to reach the entire constituency of the church.

MR. CASWELL: I don't question what the answer will be Mr. Grysbale. I am just wondering why it has confined. Perhaps this is because of the material available to your organization to take a survey. No doubt whether it is larger or smaller the people would answer in the affirmative. I was just interested to know if it was on a wide scale, and if so why I did not become acquainted with this before.

REV. GRYSBALE: In further reply to the sample



1 itself, of course, is one might think of as relatively small
2 but it is so chosen in accordance with approved methods of
3 social research that it will be fully representative, in
4 spite of the relatively small size. Two thousand as against
5 perhaps several million in the total constituency but in order
6 to carefully analyse the attitudes, beliefs, practices of the
7 people by modern methods it is better to have a small sample,
8 that is not too small but small enough you can manage the
9 data. I think that the method itself is -- I can defend the
10 method quite fully and while the returns on this particular
11 point are not complete, our sample has not been fully
12 completed, there are sufficient returns to indicate that
13 this is likely to be the feeling of our United Church
14 constituency of Ontario.

15 THE CHAIRMAN: Mr. Caswell would you mind me
2 16 interjecting a request here? If this survey is being made
17 through the form of a questionnaire -- is that correct?

18 REV. CRYSDALE: Yes.

19 THE CHAIRMAN: Would you mind submitting for
20 this Enquiry a sample of your questionnaire?

21 REV. CRYSDALE: I have a copy here sir.

22 THE CHAIRMAN: If you just leave it with the
23 Secretary, that will be fine. When it is completed, then
24 if you would give us the final results of it ---

25 REV. CRYSDALE: Yes. May I just observe sir this



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Secretary, that will be fine. When it is completed, then

if you would give us the final results of it --

MR. CHURCHILL: Yes. May I just observe at this



1 question is only one among many many aspects of social, commun-
2 ity and religious life.

3 MR. CASWELL: Mr. Hord the Church is very much
4 opposed to a means test as being a manner in which it lessens
5 the dignity of a person and this is also in line with almost
6 every brief we had. Every brief is opposed to a means test.

7 This is of great concern to this Commission.
8 Mrs. Ridell suggests that the plan in New Zealand is a very
9 acceptable one and that the premiums are paid largely on the
10 basis of income. What is the difference between an income
11 test and a means test?

12 MRS. RIDELL: Mr. Chairman, everybody is subject
13 to the same thing. I mean it is based on, for instance, one
14 shilling or one and six or two shillings in the pound so there
15 is really no means test in connection with that. Everybody
16 pays, your gardener, your maid, your laundress, as well as
17 your top executive and it is simply a question that they pay
18 according to what their income is.

19 MR. CASWELL: I understand that Mrs. Ridell.
20 There must be some manner of proving what their income is.
21 They go by their income tax statement or some other form.

22 MRS. RIDELL: It is up to your employer. I
23 mean every employer is responsible for seeing that the person
24 that they employ -- they have social security books and you
25 are responsible as an employer seeing that this is filled with



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1 these stamps and so in that way they are able to tell what the
2 income is. For some employed people I should think it would
3 have to be -- there would be other safeguards that they were
4 making a proper statement.

5 MR. CASWELL: We are interested because I do
6 not see too much difference between a means test and an income
7 test and this is what you are suggesting.

8 MRS. RIDELL: Except that in the means test
9 you are separating a section of your population. Whereas, in
10 the other test, just like your income tax now, you fill it
11 out according to your income. It's a matter of you don't
12 have to go before a Commission. You don't have to be subjected
13 to a lot of questions which you would in the means test.
14 You simply fill it out as a matter of course as you would
15 your income tax.

16 MR. CASWELL: You therefore would support a
17 graduated contribution towards medical service based on income?

18 REV. HORD: I beg your pardon?

19 MR. CASWELL: The Church would support a
20 graduated contribution towards medical service based on
21 income?

22 REV. HORD: I think that this is our idea of
23 more by contributory; that we do like everyone to feel they
24 are giving according to their ability to pay.

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1 what you want to call it. It means you are going to pay accord-
2 ing to your ability to pay. There must be some way in which
3 you prove your ability to pay.

4 MRS. RIDELL: You don't have a means test, a
5 so-called means test. You can fill it out like you fill out
6 your income tax.

7 MR. CASWELL: It's very much the same.

8 REV. HORD: May we for enlightenment, does a
9 person in order to fill out this means test, do they become
10 sort of an object of charity?

11 MR. CASWELL: We would hope not. This is part
12 of the problem we are having. We would hope there would be
13 no thought of charity associated with it at all but you are
14 suggesting that they do according to income, and personally,
15 not speaking for the Commission, I think this is a good
16 suggestion but still it seems to me you must prove your income
17 is \$2,000, \$5,000, \$10,000 and to prove it there must be
18 something to substantiate it.

19 REV. HORD: Perhaps Mr. Crysdale would like to
20 comment. I think it is our different reaction to means test.
21 From our viewpoint this is almost volatile. This is the
22 older idea of charity.

23 DR. BUTT: I'm sorry to interrupt. This was
24 the reason I brought up, having listened for many years -- you
25 have brought up a rather volatile word when you use charity.

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1 Now Mr. Crysdale has, in the process of semantics certainly
2 explained it to my satisfaction, certainly to my interpret-
3 ation. Now if I may be so bold at this point to say you are
4 now taking words and producing, shall I say, a reaction to
5 them which I don't think is quite fair to the people who are
6 trying to interpret correctly such statements as Mrs. Ridell
7 has said with regard to New Zealand.

8 In other words, I think that the word charity,
9 you give it another connotation to that which is ordinarily
10 used by the Church.

11 REV. HORD: Now what about a means test?

12 DR. BUTT: Taking the word means test, you have
13 used this in a volatile way, I think. This is not a debate,
14 this is merely for our clarification. Mrs. Ridell has used
15 it according to means test, which I think it quite acceptable
16 among many people down under, as they say, and this has not
17 produced a lack of independence. I think this is our problem
18 when we listen to this sort of brief, and we are quite
19 sympathetic.

20 REV. HORD: Perhaps Mr. Crysdale would like
21 to reply to that.

22 THE CHAIRMAN: Ladies and gentlemen, if I thought
23 this would only take you a minute or two, I would permit
24 you to do so, but we did decide we would have a ten-minute
25 recess at a quarter after eleven. We are three minutes past

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to reply to that.

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1 a quarter after eleven now. I think we will take a ten-minute
2 break here and reconvene at about eleven-thirty, not later than
3 eleven-thirty.

4
5 ---A short recess.

6
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8 MR. CASWELL: I would just like to ask one
9 or two other questions. I take it that the Church is in favour
10 of an all-inclusive, or comprehensive medical care plan which
11 would be operated by the government and not by private carriers?
12 This is my thinking from the brief that you have presented.

13 REV. HORD: We do not have anything against
14 private carriers. We wouldn't be opposed to them. But we
15 feel that this is going to be a limited scheme, perhaps more
16 like the Alberta situation, where 20 to 30% of the people might
17 belong.

18 MR. NAYLOR: No. That is not right. It is
19 quite a bit higher than that, actually.

20 MR. CASWELL: The other thing I would like to
21 get the church's feeling on is this. It has been suggested
22 to us, by others, that the present welfare plan, which is
23 administered by the Ontario Medical Association in co-operation
24 with the government, is reasonably satisfactory and successful
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1 operated in this manner, rather than go into the general
2 insurance scheme. Would the church feel that this would be
3 good or would they feel that this is segregating a group of
4 people who are accepting charity, rather than being a member
5 of the overall insurance scheme?

6 REV. HORD: We haven't discussed this in
7 detail. We recognize that there will always be a group of
8 needy people who will have to be cared for. But our concern
9 is that we do not increase that number.

10 MR. CASWELL: Do you feel that if these people,
11 instead of being welfare recipients, treated by the Medical
12 Association, paid for by the government, shall we say, they
13 can't help but be, in some manner shape or form, set aside
14 in a class by themselves -- that this is good or bad, or
15 that they should simply have their insurance card like every-
16 one else and, therefore, when they went to the doctor, even
17 though the doctor might know they are being paid for by the
18 government one hundred per cent, that they wouldn't feel they
19 are in a class by themselves?

20 REV. HORD: Perhaps Mr. Crysdale would comment
21 on that.

22 REV. CRYSDALE: I think, Mr. Chairman, that the
23 intent of our submission would support such a suggestion,
24 that so far as possible the welfare -- that the separation
25 of welfare recipients would be reduced -- separation from the

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on that.

MR. GRYSDALE: I think, Mr. Chairman, that the

intent of our submission would support such a suggestion, that so far as possible the welfare -- that the separation of welfare recipients would be reduced -- separation from the



1 larger society. But the intent of the submission would be,
2 I think, that we would favour the inclusion of welfare people
3 in the overall plan.

4 MR. CASWELL: So they would not be set aside
5 by themselves?

6 REV. CRYSDALE: With regard to the question
7 concerning means test, is it permissible to deal with that,
8 Mr. Chairman?

9 THE CHAIRMAN: Yes.

10 MR. CRYSDALE: Very briefly, I think the problem
11 arises, if I may be permitted to say so, not from originally
12 that fogginess in our submission, but with a great uncertainty
13 written into the Bill itself as to the definition of those
14 who are to be in receipt of the additional care under the
15 proposal. And this does stir, in the minds of many people,
16 serious questions about the proposal: How would the Bill,
17 the provisions of the Bill 163, determine those who are to
18 receive the proposed care?

19 THE CHAIRMAN: Presumably you refer to the
20 sentence, under Schedule C, that says:

21 " . . . if they are in needy circumstances."

22 REV. CRYSDALE: Yes, sir, precisely. And may
23 I just make this brief observation, further, that I think that
24 the public feeling must be taken into account in change of
25 social policy, and public feeling is most resentful of any

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I just make this brief observation, further, that I think that the public feeling must be taken into account in change of social policy, and public feeling is most essential of any



1 proposal to extend "means tests" -- in quotes.

2 I think this could be traced back -- if I
3 may hazard an opinion here -- to the days of the depression,
4 when large numbers of people no longer found it possible to
5 be independent and found it necessary, to support a family,
6 to apply for welfare and they were subjected, by a hard-
7 pressed government under very difficult conditions, to a
8 means test. This seemed to be the best expedient available
9 at that time, under general conditions of unemployment and
10 depression.

11 But it is felt that to extend the "means test",
12 in quotations, by whatever method the government may employ,
13 would suggest a return to hard times. I think this is part
14 of a general reaction against the use of the term, by any
15 definition.

16 I do recall, myself, the hardship that was
17 brought upon some families who were tottering at the edge of
18 independence, and who were obliged to dispose of their few
19 remaining assets before they could become eligible for
20 welfare, under a means test.

21 THE CHAIRMAN: What you have suggested is a
22 universal plan that would be paid for by taxes and, therefore,
23 all health services would be available, therefore, to all
24 people and anyone going to a doctor would then not have to
25 expose his financial situation in order to obtain physician's

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1 services or any other health service?

2 REV. CRYSDALE: There is that one qualification,
3 that we would not make it a free service but a contributory
4 service.

5 THE CHAIRMAN: Then as soon as you put it on
6 a contributory basis, is it not right then that you have
7 to define who contributes?

8 REV. CRYSDALE: There is a very clear distinction
9 between a means test, with the connotations that I have
10 suggested in my previous comment, and a distinction by
11 level of income, and if such a test on the level of income
12 were applied, I am sure that we would have no objection.

13 REV. HORD: I think you are looking at this
14 from two different ways. On your income you are trying to
15 get out of paying, but with a means test you have to get
16 this in order to get something. You are looking at it from
17 two different viewpoints.

18 DR. BUTT: I am trying to say something, for
19 clarification, Mr. Chairman. You take the words "means test",
20 the same as you take "charity" and you say it has certain
21 evil connotations, or whatever emotional things the church
22 wishes to put on it; but at the same time, you say that those who
23 have a certain income should pay it and there is nothing
24 wrong with that. So, having income is good and not having
25 it is bad. You say that you have a contributory scheme. You

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REV. HORD: I think you are looking at this

from two different ways. On your income you are trying to

get out of paying, but with a means test you have to get

this in order to get something. You are looking at it from

two different viewpoints.

DR. BUTT: I am trying to say something, for

classification, Mr. Chairman. You take the words "means test",

the same as you take "charity" and you say it has certain

evil connotations, or whatever emotional things the church

wishes to put on it; but at the same time, you say that those who

have a certain income should pay it and there is nothing

wrong with that. So, having income is good and not having

it is bad. You say that you have a contributory scheme. You



1 say everybody should contribute. Now, we feel there are
2 certain people who can't even contribute anything. How do
3 you help them and how do you identify them?

4 Is this being a means test, in the evil sense
5 of the word? I mean, you have admitted, or suggested, that
6 you wish a contributory scheme. We are merely trying to
7 clarify exactly what you mean and how you wish it to be done
8 and not feel there is anything emotional about it.

9 REV. CRYSDALE: There are others far better-
10 qualified than I to attempt a precise definition. This is a
11 key problem that I gather is involved in the proposal of Bill
3 12 163; therefore I would hazard an opinion. I would suggest
13 that those who are at present on welfare, or who are in
14 receipt of Mother's or Widow's pensions and like provision
15 by government for their basic needs, would certainly not need
16 to be subjected to a further means test. I would suggest
17 also that those who are what we call marginal families, the
18 great numbers in our population on whose behalf we are really
19 making this submission today, should not be reduced to depend-
20 ency by submission to a means test.

21 Those are the two extremes.

22 I fail to see that there should be a basic
23 confusion. If you are going to have a contributory plan, the
24 great majority of people who are in receipt of regular income,
25 by whatever means, have already declared that to the income



say everybody should contribute. Now, we feel there are certain people who can't even contribute anything. How do you help them and how do you identify them?

Is this being a means test, in the evil sense of the word? I mean, you have admitted, or suggested, that you wish a contributory scheme. We are merely trying to clarify exactly what you mean and how you wish it to be done and not feel there is anything emotional about it.

REV. CAYSDALE: There are others far better-

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Those are the two extremes.

I fail to see that there should be a basic confusion. If you are going to have a contributory plan, the great majority of people who are in receipt of regular income, by whatever means, I have already declared that to the income



1 tax and it is available to the government through the T-4 forms.

2 I see no great difficulty. I cannot understand the problem.

3 DR. BUTT: I think we are in actual agreement.

4 In other words, you have said what we call Schedule C, you
5 see no reason for changing this -- they are in receipt of
6 the welfare?

7 REV. CRYSDALE: Yes.

8 DR. BUTT: We seem to be in agreement on this
9 point.

10 REV. CRYSDALE: Yes.

11 DR. BUTT: So we are not in disagreement now.

12 Now we say there should also be harmony on the social marginal
13 group because we feel -- or I should say just personally --
14 at this point the Bill has said that these people shall be
15 helped with no further identification than their income tax,
16 which they have already done?

17 REV. CRYSDALE: Yes.

18 DR. BUTT: So, now, those two points are
19 resolved?

20 REV. CRYSDALE: Yes.

21 REV. HORD: Would there be a comparison here,
22 like a universal pension, that everybody likes to be in the
23 same setup?

24 DR. BUTT: No. I do not think there could be
25 because your very able confrere has pointed out the details to



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because your very able confere has pointed out the details to



1 my satisfaction and we are in perfect agreement with what is
2 stated. When you bring up another point, I think you are
3 changing the connotation of your words. This is what has
4 left me with a certain amount of difficulty. Thank you.

5 MR. CASWELL: I just want to ask one more
6 question for information. In your submission you mentioned
7 the difficulty and need for many people today to have avail-
8 able to ~~them~~ shock treatments, and so on. Have you found it
9 difficult for people to get this type of treatment? It is
10 not my understanding that such is the case.

11 REV. HORD: This gets into a very high
12 cost area of psychiatry.

13 Now, it is almost impossible for the average
14 person to pay for private psychiatric services. So we get
15 here into the necessity of, say, at the Ontario Hospital
16 having a clinic, a public clinic, whereby people will get
17 certain basic, necessary services. If they are depressed, they
18 should have service, the same as the well-to-do person who
19 can pay for a private psychiatrist.

20 MR. CASWELL: I wasn't thinking of psychiatry.
21 I was thinking of the cases where their family doctor or
22 a physician suggested or felt that their case could be improved
23 by shock treatment, for example and, to the best of my
24 knowledge, under his application this is available.

25 REV. HORD: I do not believe that the average



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I was thinking of the cases where their family doctor or

a physician suggested or felt that their case could be improved

by shock treatment, for example and, to the best of my

knowledge, under his application this is available.

REV. HORD: I do not believe that the average



1 doctor that administers it, though, has to be referred. This
2 is very costly.

3 MR. CASWELL: No. He is able to refer them
4 to an Ontario hospital where this can be done at no cost to
5 them. That was all.

6 DR. GALLOWAY: Would you explain that a little
7 further about the high cost of the public ward shock therapy.
8 This is a untrue statement, as far as I am aware.

9 REV. HORD: This is an idea, that we would
10 foster this type of . . .

11 DR. GALLOWAY: You haven't explained.

12 REV. HORD: . . . an extension of this service.

13 DR. GALLOWAY: But this is available at no
14 cost to anybody.

15 REV. HORD: This is good.

16 DR. GALLOWAY: What makes it high cost, then?

17 REV. HORD: It is the psychiatric care that
18 is costly -- the specialist's care.

19 DR. GALLOWAY: This also is available at no
20 cost to the people who attend the clinic.

21 REV. HORD: This is excellent. We would commend
22 this service very highly.

23 REV. CRYSDALE: Mr. Chairman, I think there is,
24 here, a suggestion implied by this comment that present
25 clinical services are adequate. May I re-direct this question to



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REV. CHRYSLER: Mr. Chairman, I think there is,

here, a suggestion implied by this comment that present

clinical services are adequate. May I re-direct this question



1 a member of the Commission. Is it the opinion of the Commission
2 that clinical services are adequate to meet the needs of large
3 masses of people?

4 THE CHAIRMAN: I do not think anyone should
5 speak for the Enquiry, but one of the doctors might wish to
6 express their personal views on this.

7 DR. GALLOWAY: If you want me to answer that,
8 I would say that in a very large area of the population,
9 adequate services are available to every person in Ontario,
10 provided they are geographically situated to obtain it. As
11 far as I know, there is no person who suffers need of medical
12 care if he wishes to avail himself of it.

13 I will speak further on that when I have an
14 opportunity of asking some further questions in this regard.
15 But if you ask me the question, I have answered it.

16 REV. HORD: We are very glad to hear this, to
17 be informed, so that we can tell our people this. We certainly
18 know a lot of our people that do not know this.

19 I am sorry, but we do not have your name, sir.

20 DR. GALLOWAY: I am Doctor Galloway.

21 THE CHAIRMAN: Mr. Naylor?

22 MR. NAYLOR: I think that the points I had
23 in mind have largely been covered by Mr. Caswell. But I would
24 like to refer to the survey again for a moment. Mr. Crysedale,
25 by the way, I am a member of the United Church, too, but I also



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23 in mind have largely been covered by Mr. G. well. But I would
24 like to refer to the survey again for a mo-
25 by the way, I am a member of the United Church, too, but I also



1 work for an insurance company.

2 REV. CRYSDALE: My father was an insurance
3 man all his life.

4 MR. NAYLOR: This was the first I have heard
5 of this survey among the members of our church and, therefore,
6 it was a surprise to me. I did not know that it was going
7 on at all and I do not believe that it has touched the city
8 where I live and, so far as I know, I haven't heard of this
9 questionnaire coming there. But you have explained that it
10 is being done by a private scientific sampling firm and I
11 understand that that will get very reliable results?

12 REV. CRYSDALE: Yes.

13 MR. NAYLOR: I think you said that it was
14 proposed to have two thousand questionnaires in your sample
15 and you indicate that this is not complete, as yet?

16 REV. CRYSDALE: No. The terms are not.

17 MR. NAYLOR: I was interested in knowing what
18 part of the sampling has given the indication that you have
19 given to us now?

20 REV. CRYSDALE: Yes. The returns from Ontario
21 so far have totalled 210 cases, which is roughly one-half to
22 one-third of the number that we will require for our entire
23 survey.

24 MR. NAYLOR: That is where you obtained the
25 67%?

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part of the sampling has given the indication that you have

given to us now?

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one-third of the number that we will require for our entire

survey.

MR. NAYLOR: That is where you obtained the



1 REV. CRYSDALE: Yes. Because of the systematic
2 and random nature of the sampling, this is considered to be
3 a fairly reliable, but not a definite, proportion.

4 It may be of interest to you, although I do
5 not have the complete figures here before me, that returns
3 6 from Toronto indicated a much higher proportion, in the Toronto
7 area, of those who would favour a government-operated tax-
8 supported plan.

9 THE CHAIRMAN: You said that there was only
10 one question on the questionnaire that related to this?

11 REV. CRYSDALE: Yes.

12 THE CHAIRMAN: For the benefit of the members of
13 the Enquiry, would you mind reading the way that that question
14 is stated?

15 REV. CRYSDALE: Yes.

16 REV. HORD: This is to get a cross-section of
17 what our people think and their attitudes and reactions, not
18 only on religious, but social issues.

19 REV. CRYSDALE: The question is No. 59:

20 "Do you favour a government-operated, tax-

21 "supported medical care plan that would provide

22 "complete coverage for everyone, at low direct

23 "cost to each family?"

24 I do not suggest, sir, that that is the entire
25 basis of our submission. The basis of our submission is

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1 contained in the brief and this is a substantiation of the
2 feeling.

3 THE CHAIRMAN: Yes. The importance of this
4 is that this could very easily be picked up by the press and
5 stated in a way that this would indicate that 67% of the
6 people of the United Church are in favour of a universal plan
7 here, and the United Church is recognized as being one of the
8 largest, if not the largest church in --- I guess it is not
9 the largest. The Roman Catholic would be -- in the country
10 and, therefore, it would be deducted that this is popular
11 with a very large percentage of the people of Canada, and there
12 would be some question in my mind as to whether or not the
13 way that that question is stated, for instance, that it might
14 be a loaded question.

15 REV. CRYSDALE: I do not deny the possibility of
16 that, sir.

17 THE CHAIRMAN: But, of course, that could be
18 argued back and forth.

19 REV. CRYSDALE: Yes.

20 THE CHAIRMAN: I would like to point out to the
21 press and this should be made very clear, that this is not
22 representative at the present that 67% of the people in Canada
23 wish

24 MR. NAYLOR: And it is only about a third of
25 what you consider to be sufficient to get you a proper sampling?

contained in the brief and this is a substantiation of the feeling.

THE CHAIRMAN: Yes. The importance of this

is that this could very easily be picked up by the press and

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1 REV. CRYSDALE: Yes. This is quite true.

2 REV. HORD: This would mean government subsidiz-
3 ation to have the low cost for each family.

4 REV. CRYSDALE: May I add further, sir, that
5 to ascertain the adequate, the feeling of the United Church,
6 there would be far more than one question on this particular
7 point. I quite agree. And the intention of the survey was
8 not to inquire into this matter alone, but the question of
9 attitudes on social questions is a highly complex matter and
10 there are, in the questionnaire, many other items which would
11 indicate an overall social policy.

12 REV. HORD: We do not wish to pose as prophets.
13 I would suggest that if there was a plebiscite that this
14 reaction would be fairly accurate, but this is only in the
15 realm of guess.

16 THE CHAIRMAN: Mr. Simon?

17 MR. SIMON: No; other than to say that I am
18 not a member of the United Church, but you have got me
19 converted.

4/rps 20 Oh, well, that's democracy, I suppose.

21 DR. GALLOWAY: I have one or two questions.
22 I'm wondering, in relationship to the United Church, exactly
23 what part you represent?

24 In other words, the corporate structure of the
25 United Church, as I understand it, has a General Council?

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1 REV. HORD: Yes.

2 DR. GALLOWAY: And who forms the General Council?

3 REV. HORD: The General Council is made up of
4 delegates, on a proportional basis across the country, and
5 these delegates are appointed by each Conference, and in all
6 the courts of our Church there are an equal number of laymen
7 and ministers, one for one.

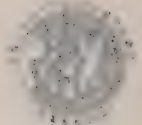
8 So it doesn't just represent a clerical voice.
9 It represents the lay voice of the Church too, and of course
10 we have the three statements by three different General Councils
11 on this particular matter.

12 This is one thing that our Church has spoken
13 of quite strongly, among others.

14 DR. GALLOWAY: And where does the Evangelical
15 Society fit into this organization?

16 REV. HORD: The Board of Evangelism and Social
17 Service is the arm of the Church, the Board of the Church that
18 is to apply the Gospel. It is evangelism and social service.
19 It's not only to win converts, but it's to apply the eternal
20 Gospel to practical social situations, as we believe this is.

21 DR. GALLOWAY: Earlier in your talk you
22 indicated that you may have misinterpreted the meaning of
23 Bill 163 insofar as the medical health insurance for the
24 indigents and the needy. From the way you continued to speak,
25 I'm rather under the impression that our interpretation, or at



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I'm rather under the impression that our interpretation, or at



1 least my own, may be somewhat different than yours.

2 I wonder if you would clarify for us just
3 exactly what your interpretation is of what this Bill will do
4 for the needy and the indigent?

5 REV. HORD: My general reaction is that it
6 won't extend the present coverage too much. It will somewhat,
7 but not too much, and the restrictions in it will likely keep
8 out many families.

9 THE CHAIRMAN: To what restrictions do you refer?

10 REV. HORD: Well, again, for one thing the
11 cost, \$192 a family.

12 THE CHAIRMAN: According to the Bill, the
13 indigent would not have to pay that cost.

14 REV. HORD: Yes.

15 THE CHAIRMAN: This would be subsidized by the
16 government.

17 REV. HORD: Yes, but I am thinking of the
18 average family. I'm thinking of our own family, of our own
19 income. \$192 a year would seem pretty high.

20 MR. NAYLOR: This is not an average figure,
21 nor a figure at all yet. It's a theoretical figure, put forward
22 as a maximum, not as an average.

23 THE CHAIRMAN: And of course the Bill does
24 state the possibility of subsidy to people who aren't indigents
25 under this definition.



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1 That's one of the responsibilities of this
2 Enquiry, to suggest to the government on what basis this
3 marginal group might receive subsidy.

4 REV. CRYSDALE: It's our hope, Mr. Chairman, that
5 the general tenor of our submission, that should what we are
6 asking for not be available, or not be granted, that perhaps
7 our submission may have caused you to add to your concern that
8 the supplementary inclusion of marginal people may receive
9 better consideration.

10 REV. HORD: It's only been pointed out that we
11 believe that a universal coverage is cheaper coverage.

12 Isn't this an insurance argument, Mr. Naylor?
13 The more universal it is, the cheaper it is?

14 MR. NAYLOR: Well, I wouldn't agree that a
15 universal plan is cheaper.

16 REV. HORD: This is a policy we share with
17 one another. In insurance this is how we bear one another's
18 burdens, so we would like to see universal coverage.

19 DR. GALLOWAY: In your brief you submit that
20 the well-to-do should look after the poor, and I'm wondering
21 wherein in this Bill you find that it will not do that?

22 Where the money is applied, the subsidies in
23 full or in part, and the poor of all grades are being
24 supported by tax funds in what area then does this Bill fall
25 down, in your opinion?

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MR. NAYLOR: Well, I wouldn't agree that a

universal plan is cheaper.

REV. HORD: This is a policy we share with

one another. In insurance this is how we bear one another's

burdens, so we would like to see universal coverage.

DR. GALLOWAY: In your brief you submit that

the well-to-do should look after the poor, and I'm wondering

wherein in this Bill you find that it will do that?

Where the money is applied, the subsidies in

full or in part, and the poor of all grades are being

supported by tax funds in what area then does this Bill fall

down, in your opinion?



1 REV. HORD: It won't be universal, will it?

2 DR. GALLOWAY: It will be universal to anybody
3 that wants it.

4 REV. HORD: Yes, well, our argument is that
5 a lot of people won't come in.

6 DR. GALLOWAY: There's one of the things that
7 you asked for, was to maintain the independence of the people,
8 and I couldn't agree with you more.

9 What greater area of independence is there than
10 the right of choice, that they will or they won't accept the
11 subsidy?

12 I can't see that they will lose their independ-
13 ence by this Bill. I can't see it.

14 REV. HORD: There are always certain penalties
15 that you sort of -- for a pension, or something, you have to
16 turn over your house, or the rights to your house.

17 DR. GALLOWAY: This has nothing to do with the
18 means test. This is the independence that you said we lose
19 through this Bill.

20 THE CHAIRMAN: You are recommending a compulsory
21 plan, in which everybody has to participate?

22 REV. HORD: Yes.

23 THE CHAIRMAN: So that you are taking away then,
24 in your recommendation, the freedom of choice as to whether
25 or not a person participates?



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1 REV. HORD: Well, it's the freedom to share.

2 We all work together on it.

3 REV. CRYSDALE: I think the same principle
4 might apply to the Workmen's Compensation. Here I don't
5 think there's an option given in the contributions to the
6 Workmen's Compensation.

7 MR. CASWELL: This is entirely different. This
8 is an obligation on a particular group, an employer. The
9 employer is obligated to protect his employee by workmen's
10 compensation, but this doesn't say for a minute that an
11 employee has to go on workmen's compensation. This doesn't
12 mean that a man employed, working there, getting hurt, he
13 doesn't even have to go to the doctor if he doesn't want to.
14 This is there for his protection.

15 REV. CRYSDALE: I realize that it isn't a
16 strictly parallel case, but the point is this, that when large
17 numbers of people are deprived of some basic necessities of
18 life, under modern expectations of life, then an action of
19 law and coercion is required to correct the situation.

20 Our concern as a Church is to preserve independ-
21 ence, but we would say that the independence of thousands
22 of families in this city has already been taken from them,
23 not through the desire of employers or insurance companies,
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25 of our society, by which formerly available resources of social

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of our society, by which formerly available resources of social



1 and private benefits in a rural community are no longer
2 available.

3 This is the kind of coercion which comes upon
4 our society under great stress of change. We can't do much
5 about that in our present stage of social science and
6 political science, but we can employ the resources of the
7 law to provide essential services for large numbers of
8 people who are caught in this situation.

9 This is the intent of the submission.

10 MR. SIMON: Assuming that this was a voluntary
11 plan, if the government would pay towards it 75, 80 or 90% out
12 of general taxation, surely it will induce everybody practically
13 to pay the balance, and participate, because everybody needs
14 health care.

15 Wouldn't you agree with that?

16 REV. HORD: They need a little encouragement
17 to belong to this scheme, I should think.

2 18 DR. GALLOWAY: At some place in your brief
19 you indicated that poor housing, inadequate food, had things
20 to do with the poor health of the community.

21 Now, in many municipalities, particularly this
22 one, low income housing is available. Do you have any
23 difficulty in your people accepting this type of accommodation?
24 This is subsidized rentals for low income groups.

25 Is there any difficulty in having the people

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Is there any difficulty in having the people



1 apply for this? I thought there was a long waiting list.

2 REV. HORD: I think the great need here is
3 for more such subsidized housing. Our Church has come out
4 strongly through the years for nationally subsidized housing
5 for low income families.

6 DR. GALLOWAY: Does this not follow along
7 then in the same tenor as Bill 163, in helping them to obtain
8 health care insurance through subsidy?

9 REV. CRYSDALE: I think the question, Mr.
10 Chairman, overlooks the basic direction of our brief.

11 With regard to housing, we don't think that
12 the final answer in the problem of housing the population
13 is subsidized housing. We would hope that the general level
14 of income might be maintained, by democratic and by economic
15 means, by government employment and private employment
16 agencies, work-making agencies, business, but we do feel,
17 returning to my former point, that there are many families caught
18 through deprivation, through no fault of their own, by which
19 they are incapable of providing adequate housing.

20 I'm glad to see that there is to be an
21 expansion of this provision, and we also maintain that there
22 should be an expansion of health services, not only for
23 strictly marginal people, but through health education,
24 and other measures, so that the whole population may enjoy
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25 the privilege, and the right, of improved health.



1 DR. GALLOWAY: I would like to ask one or two
2 more small questions. These are all minor.

3 REV. HORD: Miss Chapman might like to make
4 a comment along those general lines.

5 MISS CHAPMAN: Supposing if we agreed that
6 a child has as much right to health care as it has to public
7 school education, and if our public school education weren't
8 compulsory, might there not be some parents who would not
9 see the point of paying for it, and the children would not
10 get it. If the taxes paid for it anyway, isn't it going to
11 mean that children are going to get care, where otherwise they
12 might not?

13 DR. GALLOWAY: Are you asking me that as a
14 question?

15 MISS CHAPMAN: Well, it's just ---

16 DR. GALLOWAY: I took it as a comment, and
17 I think it's very good for the record to be there.

18 One of the points that you brought up was the
19 geographically handicapped people, and I can certainly see
20 that in the area of Hornepayne which you have indicated, there
21 is a problem for these people who live there.

22 I also listened with some interest to the
23 fact that the geographically handicapped in Oak Ridges have
24 a very real problem, and I understand they are about five
25 miles from a doctor. My understanding is that there are some

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miles from a doctor. My understanding is that there are some



1 ten doctors.

2 What do you think is the situation that should
3 be established in this province to eliminate this geographically
4 handicapped?

5 REV. HORD: Mr. Winch, of course, pointed out
6 that his community is a little more economically depressed
7 than the average, but here again, if these families belonged
8 to a universal plan, if they were covered, they would go to
9 the nearest clinic.

10 He mentioned the terrible dental situation,
11 but they are discouraged now because they just can't afford it,
12 you see.

13 Now, they need encouragement to go to the
14 nearest doctor, and our other point is there should be a clinic
15 within reasonable distance. I happen to be ---

16 DR. GALLOWAY: What is reasonable, sir?

17 REV. HORD: I think that this could be
18 worked out on a geographic area and population area. I
19 would also go -- we have mentioned in here to have a plane,
20 that would go out with a nurse and bring these people in, as
21 part of the government plan, you see, but I do think that
22 there would have to be some government leadership in saying
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1 doctors will respond to opportunities.

2 I say here that one thing the government could
3 do is to encourage more doctors for training and so on.
4 This is one great need, so that there will be adequate supply
5 of doctors and nurses, but I think there needs to be some
6 relocation, some plan here.

7 I happen to have been brought up, or spent
8 my ministry for 15 years, in the Swift Current medical health
9 plan of southwestern Saskatchewan, where they have had it
10 since 1948, I believe, and formerly where there wasn't a
11 hospital in a town a new hospital was built. Doctors
12 were supported, were encouraged to come in, given adequate
13 income. There was a great change in that Swift Current area,
14 and that was long before the Medicare crisis in Saskatchewan
15 recently.

16 DR. GALLOWAY: We're quite aware of that being
17 a tremendous medical and social experiment ---

18 REV. HORD: Yes.

19 DR. GALLOWAY: And it was a very worthwhile
20 one. I really don't know the answer to this business of five
21 miles. I would think that on the average, with the patients
22 that I see in a day, that the minimum distance of travel
23 would be closer to 15 miles. I see people from Oak Ridges,
24 and as far as I know they have neither transportation nor
25 economic problems, and I was wondering if you were going to speak



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1 of Oak Ridges as a depressed area?

2 Are they depressed medically? Are they so
3 without medical insurance and social welfare that these
4 people are truly handicapped? I can't believe it.

5 They've got medical welfare, and they've
6 got health insurance, and this must cover a very large
7 proportion of our people, particularly if you answer in the
8 same breath -- I noted in, I think that brief, but it may
9 be in one of the others, one of the problems here, and one
10 of the reasons for making compulsory state-supported health
11 care is to support the people who have mortgages on their
12 homes, loans on their automobiles and their furniture, and
13 I wonder how you can justify a state-supported plan supporting
14 these mortgages on cars and furniture?

15 /rps REV. HORD: Unfortunately it is a fact of life.
16 Now, I bought a new home. It is double mortgaged for the
17 whole amount. That is the only way I could get a home. I
18 wish I knew the answer, but this is a fact of our life,
19 our people are highly mortgaged. They are paying heavy
20 bills, not a television set in our case, a 'fridge and so
21 on, but for a house. We have a double mortgage for the
22 whole amount for 25 years.

23 I think in this regard, doctor, I notice Mr.
24 Winch says it differently. You seem to be dealing with some
25 of the same people. He says it a little differently from the

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1 way you do. I think, gentlemen and ladies, this is where we
2 have to get our heads together and exchange our views. We
3 are trying to bring a little breadth and dimension here..

4 DR. GALLOWAY: I don't really have any other
5 questions.

6 THE CHAIRMAN: Have any of the members of the
7 Enquiry further questions?

8 MR. MAJOR: I have a couple of questions if
9 you will bear with me. Mr. Hord, on page 7 of your brief,
10 the last paragraph, sentence one you are talking about
11 frequent visits to houses. Can you give me any idea of the
12 number of men, and maybe women who are in the Province of
13 Ontario doing work of this kind?

14 REV. HORD: Is this the last sentence before
15 two?

16 MR. MAJOR: The last sentence before section
17 two.

18 REV. HORD: And your specific question is?

19 MR. MAJOR: Have you any idea of the number
20 of members of the ministry, qualified members of the ministry
21 who are actually doing this work throughout the Province
22 of Ontario?

23 REV. HORD: In chaplaincy work, in hospitals . . .

24 MR. MAJOR: No, the people that are going out
25 visiting homes.

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1 REV. HORD: Oh, I think every minister does this.

2 MR. MAJOR: How many ministers are there in
3 all faiths, have you any idea?

4 REV. HORD: I am not certain, no.

5 MR. MAJOR: You couldn't make a guess?

6 REV. HORD: This would represent our demonination,
7 the paragraph below there where we have 2,285 preaching
8 places. The pastoral charges that represent our ministers,
9 1,235 pastoral charges with a number in cities like Toronto
10 with two ministers, and perhaps other social workers or
11 deaconesses who might visit. You would have to pro-rate for
12 the location of pastorates and so on. I would say that the
13 custom of most of our ministers is to visit the homes of
14 their people as soon after they become a charge as possible.
15 Many of us don't get around regularly thereafter because of
16 the mobility, we are always visiting new people. In my
17 pastorate, looking back at it I can tell every house number
18 where so and so lived practically right across my membership
19 because I have been in every house.

20 MR. MAJOR: I gathered there would be in
21 your staff, the United Church staff a professional sociologist;
22 is that correct?

23 REV. HORD: Mr. Crysdale is trained in this
24 field and is working on his Ph.D. at this time.

25 MR. MAJOR: Have you got a professional economist

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2 REV. HORD: In our former brief the Chairman
3 was an economist.

4 MR. MAJOR: This brief to the Royal Commission?

5 REV. HORD: This is just abbreviated. It is
6 the same material as this abbreviated and Mr. Grant, Dr.
7 Grant said he has done an excellent job. He is an economist
8 with a leading company in the City of Toronto.

9 MR. MAJOR: On page 15, the third paragraph:

10 "The United Church believes that such
11 "accredited chaplains should be given their
12 "rightful status and adequate salaries not
13 "unlike those of medical staff members".

14 For the benefit of this Enquiry I am going to
15 make a statement I want you to criticize. I gather from
16 this that in the medical team you feel that a pastor should
17 be associated with this medical team for the rehabilitation
18 of the patient and this pastor should be paid a certain
19 sum of money related or equitable with the amount of money
20 that is being paid to other members of that team.

21 Could you develop this for us, just how much
22 money, what kind of payment should be made? Maybe to help
23 you there might be a surgeon on the staff and for argument's
24 sake his salary is X thousand dollars, or maybe an internist
25 with this particular unit. We put a pastor into this unit.



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1 Have you any idea in your mind or the minds of your Church
2 as to what sort of remuneration should be paid to the pastor
3 as a member of this team?

4 REV. HORD: Our reaction was first of all we
5 wouldn't want the minister or clergyman to be visiting in
6 the hospital if they weren't accredited and wouldn't expect
7 them to be accepted as part of the team unless they were
8 full accredited by standards which are now available like
9 at the Boston school.

10 MR. MAJOR: I have assumed that.

11 REV. HORD: This would only be a limited number
12 because we only have a few ministers taking this accredited
13 course, but we are holding clinics in Hamilton, Toronto,
14 Queen's and in other centres whereby our clergymen are
15 becoming more qualified in this field.

16 My own idea would be that a chaplain accredited
17 and passed by the Canadian Council of Churches -- we wouldn't
18 expect the government to tie in with each denomination, we
19 feel this should be done with the Canadian Council of Churches
20 say at the Ontario Hospital for Mental Health at New
21 Toronto, Queen Street and so on where the chaplains, fully
22 accredited, could meet the needs of their people. I would
23 hope that they would be on the going salary of their fellow
24 clergy in the Church, and I would hope they would be paid
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1 If they were accredited, I would hope that
2 they would be taken into the full confidence of the doctor
3 and psychiatrist and the healing team, that they would be
4 consulted and brought into consultation.

5 MR. MAJOR: Mr. Hord, my point is the salary you
6 spoke of for these people, payment, remuneration -- you
7 wouldn't be prepared at this time to ask the government to
8 pay his payments through this Bill. Their remuneration would
9 be paid as it is normally now on the same classification and
10 through the church with which they worked.

11 REV. HORD: At the present time it is my
12 understanding, for example, that our chaplain at the Ontario
13 Hospital in New Toronto, who I happen to know, is paid by
14 the government through the hospital, so I would think if that
15 is the present situation that this should be continued.

16 MR. MAJOR: In other words is the chaplain
17 paid as it were through the Ontario Hospital Services
18 Commission?

19 REV. HORD: Yes, as I understand.

20 MR. MAJOR: You would therefore recommend that
21 these chaplains also be paid the amount of money through
22 Bill 163 as a medical unit, part of a medical unit?

23 REV. HORD: No. The situation in general
24 hospitals is different. Here the Church pays our chaplains to
25 the general hospitals. I think our reaction would be we would



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If they were accredited, I would hope that they would be taken into the full confidence of the doctor and psychiatrist and the healing team, that they would be consulted and brought into consultation.

MR. MAJOR: Mr. Hord, my point is the salary you

spoke of for these people, payment, remuneration -- you wouldn't be prepared at this time to ask the Government to pay his payments through this Bill. Their remuneration would be paid as it is normally now on the same classification and through the church with which they worked.

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1 be glad to continue this arrangement provided these men were
2 accredited and they would be accepted as part of the team.

3 MR. MAJOR: I feel better. I was wondering
4 where my donation to the Church was going to go. Now, page
5 16, the last paragraph the first sentence of it, separate
6 from the second section, you are talking here about health
7 education. This is a very broad field. What I would like to
8 clarify for the benefit of the Committee is how far your
9 health education should go, because it is my personal opinion
10 there is a great deal of health education done by the
11 medical profession today, and I am not too sure you agree
12 with that opinion because you sort of compare the old-fashioned
13 doctor with the new class of doctor. I have listed here
14 several items as to how far this health education should go.
15 I would like you to help me determine the limits the government
16 would go. I wrote this down.

17 There is health education with respect to
18 smoking, alcohol, drugs, venereal disease, water sanitation,
19 proper heating, air conditioning, squirrels, pidgeons,
20 pasteurized milk and so on. You realize squirrels are
21 carriers of the plague. You can't kill them. What do we do
22 with them? How far does the government go under Bill 163
23 if they decide health education would become part of the
24 Bill?

25 REV. HORD: I appeal to Miss Chapman on this.

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REV. HORD: I appeal to Miss Chapman on this.



1 MISS CHAPMAN: I would hope health education
2 would be done by public health personnel that would be in
3 that area and they would know whether their problem was
4 squirrels or water or whatever and emphasize the thing that
5 seemed most important at the time insofar as their facilities
6 allowed.

7 MR. MAJOR: Is that not being done now?

8 MISS CHAPMAN: Yes, but I think it could be
9 done a great deal more.

10 MR. MAJOR: The government could do a better
11 job if it is included in Bill 163 than it is under government
12 regulations now?

13 MISS CHAPMAN: I think probably through
14 existing public personnel and the facilities they could do
15 a great deal more once that became a part of their program
16 because all they would need to do is enlist a lot of public-
17 spirited people in the area to help them in one way or the
18 other.

19 MR. MAJOR: Would you be happy if the govern-
20 ment upgraded its present program and not include it under
21 Bill 163?

22 MISS CHAPMAN: Yes.

23 REV. HORD: I hope you appreciate we were
24 trying to think through the general subject in this original
25 brief.



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1 MR. MAJOR: I appreciate that. You have
2 done an excellent job on your brief. It is a matter to
3 clarify, to see what the association might accept. In
4 the second part you are talking about preventive activity of
5 some of the departments and some of the organizations such
6 as the Red Cross and the Health League of Canada and so on.

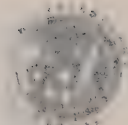
7 Let us consider all these organizations in
8 toto for a second and if we did develop in this Province
9 a very comprehensive medical care approach, and I am using
10 medical in its broadest term, would you visualize a few
11 years hence that all of these organizations would disappear,
12 the organizations you are talking about here, the Red Cross,
13 the Health League, the Red Door and the Blue Door; would
14 these things disappear?

15 These are now looked upon as some kind of
16 economic necessity in our capitalistic competitive setup.
17 If this were on a compulsory basis would these disappear as
18 there would no longer be the economic necessity?

19 REV. HORD: I would think there would always,
20 sir, be a International Red Cross.

21 MR. MAJOR: I am thinking of the Province of
22 Ontario.

23 REV. HORD: And St. John's Ambulance at the
24 football games and so on, and that emergency type of thing.
25 However I would think that some of these might disappear and



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1 could be done away with. How many arthritic ---

2 MR. MAJOR: And the money that is now being
3 expended one way or another ~~within~~ these organizations could
4 now come into the comprehensive program.

5 REV. HORD: They could and there will likely
6 be emergent needs.

7 MR. MAJOR: Consolidate?

8 REV. HORD: Yes.

9 MR. MAJOR: I was interested and I can't help
10 but bring this up:

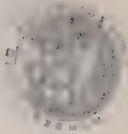
11 "It is reported by the Alcoholic and
12 "Drug Foundation of Ontario that there are
13 "alcoholics in Ontario".

14 REV. HORD: It is 94,000 -- it is page 18 under
15 care of alcoholics, second line. There are now 94,000 to
16 100,000 alcoholics in Ontario, 94,000 to 100,000 altogether.

17 MR. MAJOR: Now, sir, on page 20, the appendix,
18 railroad towns. Was this used in your submission to the
19 Royal Commission?

20 REV. HORD: Yes, under a different name.

21 MR. MAJOR: Did your economist make any
22 remarks as to whether or not it would be better to close the
23 town up and move them somewhere else than to put in all the
24 comprehensive health care? Was there any attempt by your
25 economist to determine the cost of that against



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remarks as to whether or not it would be better to close the

town up and move them somewhere else than to put in all the

comprehensive health care? Was there any attempt by your



1 the cost of keeping this town alive.

2 REV. HORD: I realize there are many railroad
3 towns who don't have train services these days, a main line,
4 they just don't stop. That is one reaction. Another reaction
5 I have, I saw a film the other evening on this strike
6 situation where the independent lumbermen, the settlers in
7 these small villages and towns along the northern railroads shot
8 three strikers because their income from cutting the lumber
9 was cut off and in retaliation they used force.

10 The C.B.C. program suggested that the annual
11 income for some of these families in the smaller villages
12 in Northern Ontario was as little as \$1,200 a year, \$1,200
13 a year.

14 MR. SIMON: \$700.

15 MR. MAJOR: Cash?

16 REV. HORD: Cash?

17 MR. MAJOR: You are talking about cash?

18 REV. HORD: Yes.

19 MR. MAJOR: On page 28 I would like to clarify
20 item 5. You say:

21 "The report points out the dangers of
22 "religious movements that stress non-medical
23 "healing."

24 We have had a lot of presentations to us from
25 people that are interested in non-medical. Do you expect us to

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"healing."

We have had a lot of presentations to us from

people that are interested in non-medical. Do you expect us to



1 take this on face value or are you indicating the non-medical
2 here has no place in society as far as your Church is
3 concerned?

4 REV. HORD: It is very interesting that we
5 are doing a study, a Committee of our Board is doing a study
6 on this matter right now. We believe in the closest co-operation
7 between the ministry, the faith, religious force on the
8 one hand and the doctors and the medical force on the other.
9 We believe they ~~should~~ tie in with complete confidence.

10 We suggested, for example, last summer when
11 Oral Roberts was in town he, at least, should have a doctor
12 and a psychiatrist on his staff to protect the people who
13 are coming there. Some of them might be in danger, their
14 lives might be in danger.

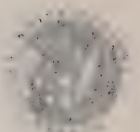
15 This is my immediate approach there, that we
16 believe that God today works through medical science in
17 performing his healing work.

18 MR. MAJOR: Are you intimating the doctor is
19 here by "divine right" like the "divine right" of kings? Is
20 there no other method of curing? Is there no other method
21 of palliating? The medical profession cannot cure everything.

22 REV. HORD: We would agree, sir, with this.
23 Mr. Crysdale suggested he has a comment.

24 REV. CRYSDALE: Mr. Chairman, may I just point
25 out for the record this on page 28 is in an appendix and not

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REV. HORD: It is very interesting that we



1 part of the original submission. It is a quotation from the
2 General Assembly of the United Presbyterian Church in the
3 United States. It simply raises the question. For our purposes
4 that there is a problem here in the relationship of science
5 and faith in the healing service.

6 MR. MAJOR: I would agree with that.

7 Let us go back, and you say you want to be on
8 the health team. What medical care do you expect?

9 There is a contradiction. I find it very
10 difficult to reconcile with all the services that are being
11 given in the Province of Ontario and generally speaking the
12 North American Continent by various organization, sects,
13 and religious organizations, and so on.

14 You intimate back here, without developing the
15 exact words, that you feel that a minister can help from a
16 spiritual basis on a health team. Now, you have said you
17 have nothing to do with the non-medical project.

18 REV. HORD: We would say everything in life,
19 including the work of doctors and drugs, has a spiritual
20 basis, and that spiritual forces are a major part. Even a
21 doctor says all he can do is cut and the rest of it is the
22 unseen forces of healing and the attitude of the patient.

23 This is where the chaplain is of use. He can
24 be part of a healing team by bringing hope to the patient.

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1 hospital ward and cannot sit down and explain things to a
2 patient is a lack here. Here is where the chaplain is part
3 of a healing team. He can come along and spend some time
4 with the patient.

5 MR. SIMON: They even forget to take out
6 instruments.

7 DR. BUTT: This is getting to one point -- we
8 should go to the point and do not agree with the Christian
9 Scientists. I will ask you a question that I asked a rather
10 eminent gentleman who sat before us and produced an excellent
11 brief and presentation. How do you personally treat an
12 appendicitis.

13 REV. HORD: Get to the doctor as fast as you
14 can. We are afraid of straight faith healing type where they
15 do not have a doctor.

16 DR. BUTT: Thank you.

17 MR. MAJOR: Just one more question. On page
18 4 of the brief you say, in broad terms, we will contribute
19 equally through society.

20 I remind you of the story that if we take all
21 the money in the Province of Ontario and divide it equally
22 amongst the citizens of Ontario, that in 48 hours five per
23 cent of the people in the Province are going to have all the
24 money.

25 REV. CRYSDALE: We have sympathy with the

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1 problem raised here. I would like to correct the comment -- I
2 am not a Communist, sir, but the word is equitable, not
3 equally.

4 MR. MAJOR: Speaking of the Communists, it
5 is said that 15% of the medical profession has been assigned
6 to areas where they have a right to go. Therefore, there
7 are medical hospitals and units throughout the Soviet Republic
8 that have no medical officer.

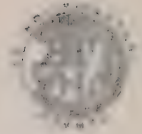
9 REV. CRYSDALE: The individual has some rights.

10 THE CHAIRMAN: For the information of the
11 people who could be here from the Osteopathic Association, we
12 plan to adjourn at one o'clock for lunch and I think we will
13 go through here so close today the way things seem to be
14 going that we will probably not have time to start your
15 hearing until after lunch. We will try to reconvene at
16 two o'clock.

17 Miss McArthur?

18 MISS McARTHUR: I was being aware that there
19 was a delegation waiting. Mr. Major's questions did raise
20 what I did have in mind but one particularly in relation to
21 public health.

22 I said the other day to a delegation that my
23 public health training was showing and I did feel that the
24 struggle for the public health provision had been accomplishing
25 something in health education. I think the questions raised by



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1 Mr. Major has taken care of some of those.

2 I did wonder and I would like to be clear of
3 the sampling on the questionnaire. I have some very definite
4 reactions on questionnaires and I did attend an American
5 university and I was taught to draw questionnaires and
6 have fought with it ever since.

7 I would like to know, again, the basis of
8 selection of the sampling. Am I right that it is two thousand
9 in Canada or two thousand in Ontario, and what measuring
10 rod is established on sampling in this regard.

11 REV. CRYSDALE: I am quite interested. I am
12 very grateful for the interest in this questionnaire.

13 To reply fully it would take some little time.
14 I spent a week's work in the sampling itself, in the selection,
15 in the drawing up of the sample in accordance with proper
16 procedure. I can only say in brevity that the latest and
17 most proved methods of sampling techniques are observed to
18 the best of my ability. They are carefully placed. There
19 is that possibility. I am also in touch with university
20 consultants in this respect. Two thousand across Canada.

21 THE CHAIRMAN: Mr. Crysdale, could you give
22 us a copy of the questionnaire. It is customary, at least
23 in my experience when you have a questionnaire, that when the
24 report is prepared on them to consider the number of people
25 included in the sampling, how they were selected, and possibly



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1 when you make up your report if we could have a copy of that
2 part of the report, it would answer Miss McArthur's question.

3 REV. HORD: Mr. Crysdale is working with the
4 Department of School of Social Work. The Department of
5 Sociology is spending quite a bit of time on survey. If
6 it does not stand up, I can assure you --- I almost said
7 he was going to be fired.

8 DR. GALLOWAY: It is two thousand out of
9 two million people or two thousand families?

10 REV. CRYSDALE: Two thousand individuals which
11 comprise a workable sample.

12 DR. GALLOWAY: Is it approximately two million?

13 REV. CRYSDALE: The constituency of the
14 United Church is closer to four million. The proportion of
15 the number of samples to the total population is not a criterion
16 in itself.

17 DR. GALLOWAY: Do you supply the samples?

18 REV. CRYSDALE: Ask Dr. Galloway what a gallop
19 pole is based on.

20 THE CHAIRMAN: I do not think we need pursue
21 this further. We will have the information from them and
22 we can get it.

23 MR. MULROONEY: You do not need the New Zealand
24 plan. My information is the New Zealand plan needed 7-1/2
25 per cent of income and wages, salaries, net income of companies

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plan. My information is the New Zealand plan needed 7-1/2

per cent of income and wages, salaries, net income of companies



1 and corporations to support the plan. This would appear to
2 be that a man supporting a family on \$50 a week in Toronto
3 is a pretty marginal income. 7-1/2% of his income would
4 represent \$19.50. It seems to me that the New Zealand scheme
5 when related to Bill 163 is no great improvement. I would
6 like to hear your explanation on your favouring the New
7 Zealand plan. You consider it 7-1/2% of income, wages of
8 wage earners. Launderers were mentioned. What makes it
9 better?

10 MRS. RIDELL: I do not think it is quite that
11 proportion because when we were out there it was 1/6d. which
12 is 1/6d. out of 20 which is not 7-1/2 per cent. The whole
13 social security scheme was based on, during the war, three
14 shillings. 1/6d. went for national defence. I believe
15 now they have raised it to two shillings for social
16 security. It now covers the whole expense of their hospital-
17 ization, medical services and so on and taken from what they
18 call the consolidated fund. It was not self-supporting but
2 19 it did a great deal. When you take it from the other point
20 of view, of how much more would have been contributed if they
21 had been on relief and welfare basis.

22 MR. MAJOR: What is a shilling -- how many
23 cents?

24 MRS. RIDELL: At the present time a New
25 Zealand pound is worth about \$2.40. It is based, very much,



and corporations to support the plan. This would appear to be that a man supporting a family on \$50 a week in Toronto is a pretty marginal income. 7-1/2% of his income would represent \$3.75. It seems to me that the New Zealand scheme when related to Bill 163 is no great improvement. I would like to hear your explanation on your favouring the New Zealand plan. You considered 7-1/2% of income, wages of wage earners. Landlords were mentioned. What makes it

MRS. KILMER: I do not think it is quite that proportion because when we were out there it was 1/6d. which is 1/6d. out of 80 which is not 7-1/2 per cent. The whole social security scheme was based on, during the war, three shillings. 1/6d. went for national defence. I believe now they have raised it to two shillings for social security. It now covers the whole expense of their hospitalisation, medical services and so on and taken from what they call the consolidated fund. It was not self-supporting but it did a great deal. When you take it from the other point of view, of how much more would have been contributed if they had been on relief and welfare payments.

MR. MAYOR: What is a shilling -- how many

MRS. KILMER: At the present time a New Zealand pound is worth about \$2.40. It is based, very much,



1 on the pound sterling. With our Canadian rate of exchange,
2 it is down a bit. A pound is 20 shillings and 20 shillings
3 was worth approximately a few years ago \$2.40.

4 REV. CRYSDALE: Whatever percentage of gross
5 income, I judge 7-1/2 per cent may be the gross national
6 product or the income of individuals, corporations.

7 MR. MULROONEY: Actual wages, salaries.

8 REV. CRYSDALE: That would be a different thing
9 of taking 7-1/2 per cent from the working man's salary.

10 MR. MULROONEY: You mentioned launderers.

11 REV. HORD: I think this is a much more
12 inclusive plan.

13 MR. MULROONEY: Do you want to relate this
14 evidence -- you speak of corporation taxes and this means that
15 the wage earner is paying the tax of corporations every time
16 he buys a gallon of gas, a package of cigarettes, a pair
17 of shoes. So that this method imposes a much greater cost
18 proportionately on those who have the lowest income. How
19 are you improving things in this way?

20 REV. HORD: I would like to know how inclusive
21 the New Zealand scheme is. For example, whether it covers a
22 lot more than this Bill 163.

23 MRS. RIDELL: It covers everything -- hospital-
24 ization, medical services, drugs, workmen's compensation,
25 family allowance. It covers everything from birth to grave.

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lot more than this Bill 103.

MRS. KIDWELL: It covers everything -- hospital-

ization, medical services, drugs, women's compensation,

family allowance. It covers everything from birth to grave.



1 MR. MULROONEY: Properly understood, the persons
2 having the lowest income and who must buy food, clothing,
3 shoes, by this method proportionately are contributing the
4 most.

5 MRS. RIDELL: 1/6d. out of 20 shillings is
6 not a terrific amount.

7 MR. MULROONEY: They are paying 1/6d. That
8 is paid from every pound paid by the Corporation which must
9 be in the prices of the pair of shoes that the child wears,
10 a gallon of gas or anything else.

11 Where does the corporation get this money?

12 REV. HORD: We believe that this should be paid
13 according to our ability of society and according to my
14 understanding this could cost \$192 for a family without
15 hospitalization, without dentist care, without drugs.

16 MR. MULROONEY: You have not ascertained properly
17 just what is included in the New Zealand scheme, but it does
18 establish that the 7-1/2 per cent might appear -- I could
19 be incorrect -- I was under the impression that this was for
20 health services.

21 MRS. RIDELL: That is what they call their
22 social security scheme. That is all-inclusive.

23 THE CHAIRMAN: Are there any further questions
24 from any members of the panel?

25 I would like to make one comment. I do not think

having the lowest income and who must buy food, clothing, shoes, by this method proportionately are contributing the most.

MRS. RIDELL: 1/2d. out of 20 shillings is

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1 there is any question in the minds of the members of the panel
2 of what you are hopeful of having, immediately or at some
3 time in the future, as you see it as far as providing for all
4 those who are in need of any type of health service.

5 I think the members of the Enquiry have had
6 a great deal of concern about your interpretation, or maybe
7 from our standpoint misunderstanding, of Bill 163.

8 I do not think we are quite clear as to whether
9 or not you have a definite plan. I got the impression that
10 you know the end result you want, and you have not put in
11 too much study on just how that end result may be obtained.
12 I think that our concern about these things is the reason
13 why so many questions were asked of you.

14 REV. HORD: Dr. Hague and members of the
15 Commission, I would like to reiterate that we do not wish
16 to enter into the economic details, and really we are not
17 trained in this field. We are just here representing the
18 needs as we see them in society.

19 We wish to thank you very much. You have been
20 most gracious and most considerate. I hope we have not
21 appeared as preaching a sermon in any regard.

22 Thank you very kindly for your gracious
23 reception.

24 THE CHAIRMAN: We will adjourn and reconvene
25 at two o'clock, at which time the delegation from the

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THE CHAIRMAN: We will adjourn and reconvene at two o'clock, at which time the delegation from the



1 Ontario Osteopathic Association will appear.

2
3 ---Luncheon adjournment.

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Ontario Ministry of Health - Laboratory Services

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--- On resuming at 2 p.m.

SUBMISSION OF THE ONTARIO OSTEOPATHIC ASSOCIATION

Appearances: Dr. D.A. Jaquith
Dr. Douglas Firth
Dr. R. Pocock
Dr. H. Hormavirta

THE CHAIRMAN: I presume this is the delegation from the Osteopathic Association?

DR. JAQUITH: Yes, sir.

THE CHAIRMAN: Would you like to proceed, Dr. Jaquith?

DR. JAQUITH: Yes, sir. Mr. Chairman, members of the Committee, I would like to introduce my Committee. On my left, Dr. Hormavirta, Dr. Pocock and Dr. Firth.

THE CHAIRMAN: You have read the instructions?

DR. JAQUITH: Yes, sir.

THE CHAIRMAN: Would you proceed, then? If you would like to be seated, that is quite all right.

DR. JAQUITH: Thank you. It was our purpose in presenting this brief, as stated in the brief, to draw the attention of the Committee to the fact that not all professions giving health services are included in the Bill and the osteopathic profession, of course, is concerned for themselves and also includes many other professions.

The free choice of physicians, we feel, is involved in this particular aspect of the Bill because each of

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involved in this particular aspect of the Bill because each of



1 these professions, including our own, have patients who rely
2 pretty well on us for their health service and if this is not
3 going to be included in the Bill, quite obviously they don't
4 have free choice of physician under the Bill. We did not go
5 into a large amount of detail. We are a small group. We are
6 a qualified group but we are a restricted group so we have not
7 attempted to outline what the Bill should be or to delineate
8 details as to operation. We feel there are many other more
9 capable people in various lines of economic endeavour that
10 could handle this better than we could.

11 We restricted our thoughts and our presentation
12 to what we thought were the terms of reference of the Bill and
13 this makes it very brief.

14 It might be easier if some of the members of
15 the Commission would like to ask us questions, having read the
16 brief, or if there are ways in which we can clarify either our
17 position or the history of our profession, we would be happy to
18 do so.

19 THE CHAIRMAN: I personally think your views are
20 quite clearly put forth in the brief. Some of the members of
21 the Enquiry would like to ask you questions.

22 DR. JAQUITH: Be happy to try and answer them.

23 THE CHAIRMAN: Miss McArthur?

24 MISS McARTHUR: Mr. Chairman, I must say that I
25 enjoyed this brief because it was brief and I did not have

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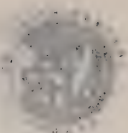
1 quite so much homework, but I also have some questions left
2 over in my mind. I wonder if I might know how many osteopaths
3 there are in Ontario? What kind of distribution there is, and
4 where are they trained?

5 DR. JAQUITH: The osteopathic population in
6 Ontario, I think, is 46. Dr. Firth thinks he can answer this
7 a little more specifically.

8 DR. FIRTH: There are 65 registered osteopathic
9 physicians practising now in Ontario; they come from a variety
10 of colleges over the years. Their training is that basically
11 of the ordinary physician in Ontario. We may not do all the
12 things that a physician may do. All the colleges at present
13 are in the United States. Any other questions?

14 DR. JAQUITH: The figure I quoted was the number
15 in our Association.

16 MISS McARTHUR: I find the statement in the
17 beginning of your brief rather interesting since I have
18 questioned many delegations on it and you say the plan of the
19 Bill in the preamble should be to encourage the use of medical
20 services by the population for the prevention of sickness by
21 routine medical examination. Are you suggesting that the
22 preamble should be so worded, as well as the deletion of the
23 exemption under Schedule A, and are you suggesting that this is
24 a philosophy or something that the osteopaths themselves would
25 take a direct part in the carrying out of the routine



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exemption under Schedule A, and are you suggesting that this is
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1 examination?

2 DR. JAQUITH: Dr. Hormavirta would like to
3 answer that question.

4 DR. HORMAVIRTA: It was our thought since 1945
5 when the consideration of the first Liberal Government was
6 proposing a health insurance bill that the purpose, the stated
7 purpose for the Government - this should be encouragement for
8 a routine - people should extend their use of examination for
9 themselves for the prevention, you know, to encourage the
10 prevention of these entities rather than wait until they
11 become ill and that this should be put into it in a broad
12 statement of aims of all medical plans, whether insurance or
13 not, but it would be the aim of the Government that people
14 avail themselves. This is the purpose - any extension of
15 medical services would be towards the encouragement of preven-
16 tive medicine, as much as for the treatment of illness once it
17 became a real entity, so it was put there - we had hoped the
18 Government would put it in its own preamble to the Bill, sort
19 of in the statement of aims of the Bill itself.

20 MISS McARTHUR: So you are stating it as a
21 statement of philosophy rather than implementation?

22 DR. HORMAVIRTA: That is right.

23 MISS McARTHUR: On page 4 you say biophysicists
24 and biochemists at the major medical research institutions are
25 adding the findings in this field. Would you mind telling me



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and biochemists at the major medical research institutions are

adding the findings in this field. Would you mind telling me



1 where these major medical research institutions are?

2 DR. HORMAVIRTA: Yes; in England, for example.
3 University of Leeds, a great deal of work under osteopathic
4 foundation. Birmingham. These are areas. Professor Stacey
5 in Birmingham has compiled the work of research workers in
6 France, in the United States, Australia; works even on one
7 aspect, "carbohydrates of living tissues." This is working
8 on musculo-skeletal, an area of connected tissue; an enormous
9 amount of work has been undertaken in the last ten years.

10 MISS McARTHUR: It is outside of Canada rather
11 than in Canada?

12 DR. HORMAVIRTA: Yes, outside of Canada. There
13 is, at the University of Toronto, under Dr. Wallace Graham,
14 a department there with some work done by one of his co-workers
15 on coligens. This is a relatively small area in comparison to
16 some of the basic research done in some other centres.

17 THE CHAIRMAN: Mr. Coulter?

18 MR. COULTER: Thank you, Mr. Chairman. Ladies
19 and gentlemen, I am strictly a layman when it comes to medical
20 terms. Would you explain to me what an osteopath is, please,
21 for my information? What your qualifications are?

22 DR. JAQUITH: Got a whole book here which it
23 takes to understand.

24 MR. COULTER: Put it in layman's language and
25 put it as brief as possible, please.



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1 DR. JAQUITH: I would say that an osteopathic
2 physician, to put it into layman's terms, taking it from the
3 layman's standard, is one who is trained in all branches of
4 medicine, specializing, perhaps, in manipulative work, body
5 structure. This is the simplest - this is not a complete
6 explanation.

7 MR. COULTER: In calling yourself a physician,
8 probably rightly so, would you be permitted to practise medi-
9 cine under this degree that you hold?

10 DR. JAQUITH: I will ask Dr. Firth to answer
11 that because he has had some conference work in that direction.

12 DR. FIRTH: Under the present laws of Ontario,
13 sir, we may not practise medicine in the broad sense in which
14 you interpret it. Whether we are physicians or not is decided
15 by the university where we graduate, the college where we
16 graduate. They tell us whether we are physicians or not. The
17 laws of all the different jurisdictions, government, where we
18 practise - this is basically a provincial or state matter
19 throughout North America, decides what we may do. In Ontario
20 we are very severely restricted. We are limited practically
21 to a very small portion of our armatorium which makes us seem
22 to be different from the ordinary, regular physician because
23 this basic manipulative type of therapy is not exclusive to
24 the osteopathic profession any more than injecting is exclusive
25 to the medical profession.



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1 MR. COULTER: Are you saying your status of
2 physician is not recognized in Ontario?

3 DR. FIRTH: This is so, yes.

4 MR. COULTER: I think you said there are 65
5 registered osteopaths in the province. What is the distribution
6 of these people?

7 DR. FIRTH: I would say basically it is within
8 the cities. There are none in rural practice in Ontario.
9 There are some in the smaller towns but I think Windsor,
10 London, Kitchener, Toronto, Barrie, North Bay has included
11 three-quarters of the profession, pretty well.

12 MR. COULTER: About how many people would visit
13 the ordinary osteopath's office in a day?

14 DR. FIRTH: That would vary, perhaps, probably,
15 from about 15 to 30. I would think somewhere in there,
16 depending on how extensive the practice was, how long a day
17 was. Somewhere in there.

18 MR. COULTER: For an ordinary visit what might
19 the charge be?

20 DR. FIRTH: The charge varies from about \$4 to
21 \$6 throughout the Province of Ontario. That is an ordinary
22 visit. There is probably a difference for a more thorough
23 examination as is frequently done in the regular medical
24 profession.

25 MR. COULTER: At the moment Bill 163 does not

MR. COUTLER: Are you saying your status of

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1 cover you, as you realize?

2 DR. JAQUITH: Yes.

3 MR. COULTER: You are requesting that it might,
4 or probably that it should. If it were, do you feel that there
5 are enough people to service the public, particularly in the
6 case of public funds being used?

7 DR. JAQUITH: We would only ask that we be
8 included so we could cover the existing practice.

9 MR. COULTER: Then are you saying that there is
10 room for many, many more osteopaths in the province?

11 DR. JAQUITH: Yes, indeed.

12 MR. COULTER: And what is being done at this
13 point to increase the number of osteopaths in the province?

14 DR. JAQUITH: Well, I would think about the
15 same that is being done to try and increase the number of
16 medical doctors in practice. Sometimes we have the same
17 problem. Dr. Firth would like to answer that.

18 MR. COULTER: What is this?

19 DR. JAQUITH: The recruiting of more students.

20 DR. FIRTH: Basically it is a cost factor. It's
21 one of the most expensive professions to graduate from, or into,
22 is the practice of medicine whether osteopathic or allopathic
23 or regular, whatever it is, seven or eight years at least is
24 required because the length of the osteopathic course is
25 basically the same as the regular medical course; measured by

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one of the most expensive professions to graduate from, or into

is the practice of medicine whether osteopathic or allopathic

or regular, whatever it is, seven or eight years at least is

required because the length of the osteopathic course is



1 the same standards throughout the group that have to licence
2 us.

3 MR. COULTER: In the foreseeable future, as far
4 as you are concerned, is there any hope of a school of medicine
5 or osteopathic college in Ontario graduating people?

6 DR. FIRTH: There is a committee working on a
7 Canadian school now. I should add, for your information, there
8 is a committee in the United States working on starting an
9 osteopathic college which will occur within the next few years,
10 in the State of Michigan, and the basic amount of money they
11 need to start is \$30 million. That is quite a bit of money
12 any way you look at it. I think some years ago the University
13 of British Columbia started a medical school there and started
14 off with a fund of about \$5 million. That is a few years back.
15 The University of Ottawa, I think, now has a medical school and
16 the funds there are very expensive, just to set up the school
17 so they could teach, train people to be physicians and graduate
18 them. Extremely expensive nowadays. The basic cost is astro-
19 nomical.

20 MR. COULTER: I think that is all I have at the
21 moment, Dr. Hagey.

22 THE CHAIRMAN: Dr. Galloway?

23 DR. GALLOWAY: My questions will be very brief,
24 sir. What Act are you licensed to practise under now?

25 DR. JAQUITH: The Drugless Practitioners' Act of



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THE CHAIRMAN: Dr. Galloway?

Dr. What Act are you licensed to practice under now?

MR. JACQUITH: The Drugless Practitioners' Act of



1 Ontario.

2 DR. GALLOWAY: You commented on there will be
3 new schools. Is it not a fact that they are becoming less, less
4 actual osteopathic schools in the United States than there
5 used to be?

6 DR. JAQUITH: I wouldn't say that as a general
7 statement. We lost one a year or so ago. So far as my know-
8 ledge is concerned no others are following suit.

9 DR. GALLOWAY: Do you know enough about the
10 insurance policies which now pay for your service to know -
11 they are listed at the back of your brief - whether these are
12 on a standard plan or whether these are on extended health
13 benefits?

14 DR. JAQUITH: No, we haven't the details on
15 that. They vary within the individual companies, as you
16 probably know.

17 DR. GALLOWAY: Do you send your accounts to the
18 company or do you send them to the patient?

19 DR. JAQUITH: It is done both ways. I think
20 frequently we send it to the patient and the patient deals with
21 the company.

22 MR. NAYLOR: It is fairly common for insurance
23 companies to pay for this under both basic and extended health
24 plans.

25 DR. GALLOWAY: Thank you very much. I really

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DR. GALLOWAY: Thank you very much. I really



1 have no further questions.

2 THE CHAIRMAN: Mr. Major?

3 MR. MAJOR: No questions.

4 THE CHAIRMAN: Mr. Naylor?

5 MR. NAYLOR: Referring again to the list on the
6 last page of your brief of insurance companies which pay for
7 osteopathic services, No. 13 is medical services, Alberta.
8 Is this the doctor-sponsored plan in Alberta of which the full
9 name is Medical Services Alberta Incorporated? Is that the
10 one that refers to?

11 DR. JAQUITH: I would assume so. I don't know
12 for sure.

13 MR. NAYLOR: If so, this was a surprise to me
14 to see this in your list. I wondered if it was correct.

15 DR. JAQUITH: That could be an error. I think
16 there is only two; not more than three in Alberta. We don't
17 have too much contact there and we certainly don't take claims
18 on this company in Ontario. At least I never have.

19 THE CHAIRMAN: Mrs. Aylen?

20 MRS. AYLEN: The list at the back of the
21 insurance companies, do you know if they limit any of the
22 services?

23 DR. JAQUITH: Many of them are limited.

24 MRS. AYLEN: Would you give us an example?

25 DR. JAQUITH: It is limited in that they will

have no further questions.

THE CHAIRMAN: Mr. Major?

MR. MAJOR: No questions.

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services?

DR. JACUITH: Many of them are limited.

MRS. AYLES: Would you give us an example?

DR. JACUITH: It is limited in that they will



1 allow so many treatments, which is the number stated, or also
2 on inquiry they give this. They don't limit the nature of our
3 service or the amount of our service.

4 MRS. AYLEN: I wanted to know whether it was in
5 frequency or amount of money.

6 DR. JAQUITH: Usually in frequency.

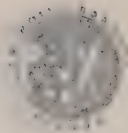
7 MRS. AYLEN: I suppose it would vary with the
8 ailment that you were treating?

9 DR. JAQUITH: That is our field, whether it
10 varies. I mean, we would go ahead and treat the patient
11 regardless of what the insurance company had allowed, but I
12 don't think they designate how many treatments they would give
13 in such-and-such a case, such-and-such a disability. I have
14 never seen that written.

15 MISS REID: What is the scope of your practice
16 in Ontario under the Act that you practise under, the Drugless
17 Practitioners' Act? What is the scope of the Act?

18 DR. JAQUITH: Well, this varies, but under the
19 Drugless Practitioners' Act, of course, we cannot write pres-
20 criptions so that we are limited in such a way that we almost
21 become specialists in manipulative structural therapy. We do
22 a good deal of general practice, some acute work. We find it
23 responds very well.

24 MISS REID: You mean general and acute in the
25 sense of manipulative work?



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sense of manipulative work?



1 DR. JAQUITH: Many acute - most acute conditions
2 will respond very well to a manipulative practice, properly
3 applied.

4 MISS REID: The Act does permit surgical proce-
5 dures?

6 DR. HORMAVIRTA: No. The Act does limit us on
7 the question of the prescribing of medication. This means that
8 we are permitted to make examination for almost any of the
9 body's system. Those who are in wide practice, electrocardio-
10 graph check-ups, check up all the systems of the body just as
11 in general medicine, but it creates problems because in many
12 areas medications are necessary and then we will need to refer
13 and this is quite true, I think, we refer a great deal to
14 medical colleagues because we know that certain areas need the
15 assistance of such treatment.

dpw 16 THE CHAIRMAN: We have had another request from
17 the reporter here to speak up loudly so that we can all hear.

18 DR. JAQUITH: Dr. Firth would like to add some-
19 thing to that.

20 DR. FIRTH: The osteopathic practice regulations
21 in Ontario are actually most peculiar in that the Act under
22 which we practise says certain things but it leaves more out
23 than it says. The other Acts governing medical care in the
24 province spell out who may do what and the Medical Practice
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1 people registered under the Act may do certain things. That
2 bars us in those phases of the overall practice of medicine of
3 which we are part, although we are only permitted to do our
4 part.

5 DR. JAQUITH: It is rather a peculiar situation.
6 We are required to qualify as a physician. We are given the
7 degree Doctor of Osteopathy. When we come into Ontario, we
8 are restricted in our practice and not allowed to call ourselves
9 "Doctor."

10 MR. MAJOR: Have you made any representation to
11 the Provincial Government about this?

12 DR. JAQUITH: Many times, sir.

13 MR. MAJOR: As I understand your situation, you
14 are trained to dispense medicine; is that correct?

15 DR. JAQUITH: That is correct.

16 MR. MAJOR: But you are not permitted to do so?

17 DR. JAQUITH: That is right.

18 MR. MAJOR: Does this stop you from advising a
19 patient as to what drug they should take, as long as that drug
20 does not come under Schedule F?

21 DR. JAQUITH: I wouldn't think so.

22 MR. MAJOR: You can do this?

23 DR. JAQUITH: A druggist can do it. Many laymen
24 can do it. So I do not see why we can't.

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MR. MAJOR: Is there any differentiation in the



1 training in the various osteopathic colleges? Are all osteo-
2 pathic colleges on the same standard of training?

3 DR. JAQUITH: Not quite. There would be the
4 same differences that there are between different medical
5 colleges.

6 MR. MAJOR: In the Province of Ontario, as I
7 understand it, there is a basic requirement for these people
8 coming into this province on the basic requirement. They are
9 allowed to try, I think the word is, the council examinations,
10 whereby they would, after an intern period and the passing of
11 their examinations, be licensed to practise medicine in Ontario.
12 In your osteopathic colleges, would your basic training be
13 such that you feel that you could, with whatever internship
14 required, pass this basic examination?

15 DR. JAQUITH: Yes.

16 MR. MAJOR: Regardless of what osteopathic
17 college graduated the osteopath?

18 DR. JAQUITH: Yes, sir.

19 MR. SIMON: Do the medical doctors ever refer
20 their patients to an osteopath?

21 DR. JAQUITH: Yes, sir.

22 MR. MAJOR: Is this a two-way street? Is it a
23 common street? You have made submissions that you frequently
24 refer patients to the medical doctor. You might be able to do
25 the job, but you are not permitted, legally, to do it?



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1 DR. JAQUITH: That is correct.

2 MR. MAJOR: So you refer to those that are
3 legally qualified to do it?

4 DR. JAQUITH: That is correct.

5 MR. MAJOR: Do you get this same street back as
6 far as reference is concerned?

7 DR. JAQUITH: Some of my colleagues say, "Yes,"
8 but I know some of us do not get as many references back as we
9 would the other way, and that is quite natural, under the cir-
10 cumstances.

11 MR. MAJOR: Does your practice in the Province
12 of Ontario, because it is limited, tend to deteriorate the
13 osteopathic physician over a period of time? I will rephrase
14 that. The recent graduate from an osteopathic college,
15 completely trained - and I will assume my own wording - in the
16 basic medical approach that would be comparable to the general
17 practitioner in the medical college, over a period of time
18 practising in Ontario, does he deteriorate as a doctor, or
19 after 15 years' practice can he still pass these council
20 examinations?

21 DR. JAQUITH: I do not think an M.D. could pass
22 the examinations after 15 years. I would like to say, though,
23 that I wouldn't call it deterioration; but we, naturally, use
24 proficiency in the prescription of drugs, when we are not able
25 to do it and don't do it.



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1 MR. MAJOR: I didn't mean deterioration in the
2 nasty sense. I mean as an accountant, if I am not doing
3 journal entries day after day, I would soon forget all the
4 things about journal entries.

5 DR. JAQUITH: That is correct.

6 MR. MAJOR: In that sense, you are not practi-
7 sing those basic things; some of them, you may be a little
8 rough in?

9 DR. JAQUITH: That is true.

10 THE CHAIRMAN: Any further questions from the
11 members of the Enquiry?

12 MR. CASWELL: How long is the course - how many
13 years?

14 DR. JAQUITH: Seven years. I think Dr. Firth
15 could enlarge on that.

16 DR. FIRTH: Mr. Caswell, there is three years'
17 pre-medical. This is all American, where there is no Grade 13.
18 You go through four years' high school, three years of medical
19 training in a non-osteopathic college, in a liberal arts
20 college, where certain subjects are specified. Then you go to
21 an osteopathic college for a year of internship, for a regular
22 physician. If you specialize, it is the same pre-requisites
23 for time and places and further examinations to be a specialist
24 and all the specialties which occur in the medical profession.

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and all the specialties which occur in the medical profession.

MR. CASWELL: What is the difference in



1 practising, for example, in Michigan and in Ontario? What
2 would you be allowed to do in Michigan that you can't do here?

3 DR. JAQUITH: You can do everything in Michigan.
4 The M.D. and D.O. degree are completely on a par - almost.

5 MR. MAJOR: What is the difference?

6 DR. JAQUITH: The difference is in our basic
7 philosophy, our basic thinking. We approach things a little
8 differently.

9 THE CHAIRMAN: You mean legally you can do the
10 same?

11 DR. JAQUITH: Yes, that is correct.

12 THE CHAIRMAN: What you would do is different
13 according to your philosophy?

14 DR. JAQUITH: Yes.

15 MR. MAJOR: Under the present practice of osteo-
16 pathy in the province, coming under the Drugless Practitioners'
17 Act - and I would like you to help me clarify my terms - your
18 approach to the practice of health is more palliative than an
19 approach to acute condition? Do you handle acute conditions?

20 DR. FIRTH: Yes.

21 MR. MAJOR: What kind of conditions would you
22 say were in this acute area?

23 DR. JAQUITH: Well, all the 'flus - even pneu-
24 monias. Sometimes we have handled an appendectomy before it
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1 to a surgeon.

2 MR. MAJOR: Any systemic disease, you would
3 handle, within reason?

4 DR. JAQUITH: That is correct.

5 MR. MAJOR: What about diabetes or a cardiac
6 condition?

7 DR. HORMAVIRTA: If it is a previously diagnosed
8 case, we wouldn't do anything. We would tell the person to
9 carry on with their own physician who had diagnosed the problem.
10 Sometimes we diagnose it ourselves. Once it is established
11 that a person is diabetic, we would have to refer them because
12 we do not prescribe.

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14 send it out?

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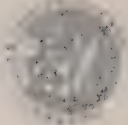
16 MR. MAJOR: Yes.

17 DR. HORMAVIRTA: No. They are sent out to the
18 laboratories.

19 MR. MAJOR: In other words, you, in your prac-
20 tice, arrive at a hurdle where you require some chemo-therapy
21 and you have to refer them?

22 DR. HORMAVIRTA: That is correct.

23 MR. MAJOR: On this basis, then, and regardless
24 of what will happen in the future as to the liberalization of
25 the laws governing your practice - do you follow me - under the



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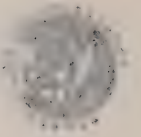
1 present circumstances, everything else being equal, how would
2 this Act apply to you, where a good bit of your work may be
3 confined to handling chronic cases of the musculo-skeletal
4 system, in which there would be ultimately an end to it? Let
5 me demonstrate, if I can, in my lay language. It is normal for
6 a medical doctor to take one or two or three, but a known,
7 reasonable number of visits to clear a case of mumps. Now,
8 can you have, generally speaking, in your practice, a number of
9 known visits to clear up and resolve a particular medical
10 condition?

11 DR. JAQUITH: Generally speaking, I would say
12 yes. But, remember, that individuals are different and cases
13 will differ in this regard. So that from that standpoint, one
14 person may require three visits; another person may require
15 five or six.

16 MR. MAJOR: Yes. Now, you are not correlating
17 this to any medical condition. Have you got a case of mumps
18 in mind that would require six visits?

19 DR. JAQUITH: Yes, absolutely. There seems to
20 be some confusion here. You answer according to your inter-
21 pretation of his question.

22 DR. FIRTH: As far as I am concerned, a case
23 of the mumps is going to get better whether they go to a
24 doctor or not, and we all know that. I do not think that is a
25 good example.



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confined to handling chronic cases of the musculo-skeletal
system, in which there would be ultimately an end to it? Let
me demonstrate, if I can, in my lay language. It is normal for
a medical doctor to take one or two or three, but a known
reasonable number of visits to clear a case of mumps. Now,
can you have, generally speaking, in your practice, a number of
known visits to clear up and resolve a particular medical
condition?
DR. JAGUITH: Generally speaking, I would say
yes. But, remember, that individuals are different and cases
will differ in this regard. So that from that standpoint, one
person may require three visits; another person may require
five or six.
MR. MASON: Yes. Now, you are not insisting
this to any medical condition. Have you got a case of mumps
in mind that would require six visits?
DR. JAGUITH: Yes, absolutely. There seems to
be some confusion here. You answer according to your
pretation of his question.
DR. RITCHIE: As far as I am concerned, a case
of the mumps is going to get better whether they go to a
doctor or not, and we all know that. I do not think that is a
good example.



1 I am thinking, for instance, of a very severe
2 acute low back, where they have been changing a tire and
3 strained their low back, of which we all know what I mean.
4 There are various ways of treating that. We like to think
5 that the care we give it gets them back to work sooner than
6 what they would get from other physicians - but not all other
7 physicians. Some give them good care and some give them such
8 poor care that we are ashamed of other doctors. We think all
9 doctors ought to be able to give equally as good care.

10 Now, under the Act as it is now, our patients
11 are concerned. They say if they are going to contribute in
12 any way, that they should have some free choice of physicians,
13 and as the taxpaying public and as physicians, we think they
14 should. We think we can provide a type of care which is not
15 available from any other group. It is, perhaps, a narrow way
16 of looking at it, but we are on the inside looking out and we
17 know what we can do. People certainly vary tremendously. It
18 is difficult to say in a case of diabetes, "You will require
19 fifteen visits" - it will require visits for the rest of the
20 person's life.

21 In some other things, for instance, a rupture
22 of the cartilage of a knee, we are not going to treat that.
23 If we are intelligent, we send it to a surgeon because we
24 cannot cure it. No one can. It is a surgical procedure.

25 A herniation of a disc, now, on the low back,



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1 which is sometimes called some weird and wonderful names, we
2 may help it and we may not, depending on that person and many
3 other factors going back many years and there is still not
4 agreement among all the physicians to treat those things.
5 And in many cases we find we will have to debate with our
6 colleagues and in many cases we can agree with them. But that
7 is the thing that makes the practice of medicine an art and not
8 a science.

9 MR. MAJOR: Right. Now, from an economic
10 standpoint, I have two questions. The average treatment
11 rendered by an osteopath, what do you charge for it? What is
12 the general charge?

13 THE CHAIRMAN: Four to six dollars.

14 MR. MAJOR: One of the things that the carriers
15 considering the Bill as it presently is written - and we have
16 no crystal ball to tell what changes are going to take place -
17 considering the Bill as it presently is written, and there are
18 a series of treatments submitted for payment; is there any way
19 in which a carrier of this particular citizen, and the Osteo-
20 pathic Association, can resolve a problem in respect to the
21 number of visits that are reasonable in this particular case?

22 DR. JAQUITH: Are you referring to Bill 163?

23 MR. MAJOR: That is correct - as it is written.

24 DR. JAQUITH: But we were not to be even
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DR. JACUITH: Are you referring to Bill 103?

MR. MAJOR: That is correct - as it is written.

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1 MR. MAJOR: No. I am assuming that if we were
2 - if the people who are carrying health insurance under this
3 Bill were called upon to pay for osteopathic services, how
4 would the carrier be able to reconcile the number of visits
5 that might be given to a particular patient in respect of a
6 particular condition and how could the Osteopathic Association
7 help that carrier?

8 THE CHAIRMAN: Is this done by the Ontario
9 Medical Association?

10 MR. MAJOR: Yes, sir. There is a method in the
11 Ontario Medical Association where anybody paying for the
12 services of a licensed medical practitioner may, under certain
13 conditions, approach the Ontario Medical Association, as an
14 organization, for arbitrary proceedings.

15 DR. FIRTH: I am not sure whether the medical
16 physician can check me up, but I think it is a joint board
17 with the College of Physicians and Surgeons, which is also
18 concerned with ethics. I am Chairman of the Licensing Board.
19 Now, recently, a few days ago, an insurance company came in to
20 me. Now, generally speaking, the ethics of a physician are
21 such that we do not worry too much; but since they are human
22 beings, we do get bad apples in the barrel and we must have
23 provision to protect the paying public from gougers and Mr.
24 Naylor, an insurance man, is much more concerned with gougers
25 from his end of the field. They are very concerned, because



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1 I keep seeing articles all the time in which the group health
2 insurance companies in the States are becoming increasingly
3 concerned with the rising costs, which they sometimes wonder
4 if they are justified.

5 MR. MAJOR: That is part of the answer. Now,
6 supposing there is an osteopathic physician, everything else
7 being equal, included in this Bill as it presently stands,
8 who was giving treatment after treatment for a particular
9 condition which, in somebody's opinion who may not be an osteo-
10 path, this condition should have been transferred or referred
11 long ago. Is there an organization that this account can go
12 to and would this organization say that, everything else being
13 equal, this patient should have been transferred to somebody
14 else to handle? Now, you spoke of a condition heading for a
15 menesectomy. Now, supposing some osteopathic physician kept
3 16 on treating this on an exercise basis, that he should not have
17 done so; is there a body that this could have been given to
18 that would rule on the case?

19 DR. FIRTH: There is the Ethics Committee in
20 both the Canadian and the Ontario Association, whose job it is
21 to rule on this as an arbitrator. There is also the Board of
22 Directors of Osteopaths or the Licensing Board. We consider
23 that, too. Actually, we have never had to consider it, but it
24 is our prerogative to do so. We run immediately into the
25 theoretical case where you might get a lot of differences of

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1 opinion in thinking; for example, an osteopathic physician
2 treating a patient with diabetes, purely by manipulative care
3 - that, we do not condone.

4 MR. MAJOR: I am thinking of it in terms of
5 pure economics. In other words, you have a choice of surgery
6 and this happens in the medical field and I imagine it happens
7 in the osteopathic field, that you could spend \$150 treating a
8 case medically, where \$75 would clean the case up. Do you
9 understand what I am getting at - that these things have to be
10 reconciled and equated to proper economics?

dpw 11 DR. FIRTH: I don't believe for one moment any-
12 body in our profession would object to having any case arbi-
13 trated, provided it was arbitrated by people they had confidence
14 in. In other words, we would have to arbitrate our own people,
15 and slap them down if they were wrong.

16 MR. MAJOR: In other words, you would recommend
17 consultants for this particular thing?

18 MRS. AYLEN: You aren't allowed to call your-
19 selves doctors?

20 DR. POCOCK: That's right, by law.

21 MRS. AYLEN: What about your patients?

22 DR. POCOCK: There's nothing to prevent our
23 patients calling us Doctor.

24 MRS. AYLEN: Do you have your number in the
25 telephone directory under Doctor?



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MRS. AYERS: Do you have your number in the
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1 DR. POCOCK: It's not under the physicians'
2 list. It's just under osteopaths.

3 MRS. AYLEN: It's just a gentlemen's agreement
4 between you and your patients what they call you?

5 DR. POCOCK: Our patients come to us for medical
6 health care, and so they call us Doctor, and they see our
7 degree hanging on the wall with Doctor on it, so we don't
8 prompt them.

9 It goes along with several other factors that
10 we consider are detrimental to getting other doctors coming
11 into the province. It's just one other illustration.

12 MRS. AYLEN: Is this true all over Canada?

13 DR. POCOCK: Well, it's true in many places.
14 We're speaking mostly of Ontario here, but there are restric-
15 tions in some of the other provinces, too, but not the same,
16 perhaps not in the use of the term Doctor, but there are other
17 restrictions.

18 THE CHAIRMAN: Do you have any further state-
19 ments you would like to make?

20 MR. MAJOR: You say that you have made various
21 representations to the Province of Ontario in respect to the
22 area in which you are licensed, and that's The Drugless Practi-
23 tioners' Act?

24 DR. POCOCK: That's right.

25 MR. MAJOR: What's the future on this? Have you

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MR. MAJOR: What's the future on this? Have you



1 been able to make any inroads in convincing them?

2 DR. POCOCK: I would like to ask Dr. Firth to
3 answer that, because he is most directly concerned with it,
4 and I hope can give you a more complete answer than I could.

5 DR. FIRTH: The outcome of nearly all the nego-
6 tiations, which go back to about 1925, when the law was
7 written, the osteopathic profession was very unhappy then.
8 They never were a drugless group, and they were popped into
9 this, and much against their will, mostly because they are a
10 minority group, and mostly because the majority group didn't
11 want us to practise what they thought was their prerogative,
12 and that's pretty much the same throughout North America.

13 So our fight has been with the College, and it
14 finally got so bad in the Provincial Government that the
15 Minister of Health, Dr. Phillips I think it was then, got so
16 fed up with our appearing there and the other people disapprov-
17 ing of what we wanted, that he said, "You people fight it out
18 amongst yourselves, and come back," and that's what we are
19 doing now, and it has been most gentlemanly, and we're very
20 glad of the opportunity.

21 DR. POCOCK: Dr. Hagey and members of the
22 Committee: thank you for your courtesy in taking the time and
23 allowing us to present our case.

24 If there's any further information you would
25 like that we can offer you -- we did not presume to send you



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1 reams of literature and so on, but, for instance, we have these
2 little books on our basic philosophy.

3 THE CHAIRMAN: If you would leave one with the
4 Secretary we would appreciate that very much.

5 DR. POCOCK: Thank you very much, sir.

6 THE CHAIRMAN: Thank you. I believe the dele-
7 gation from the Ontario Federation of Labour is here.

8 Would their delegates please come forward?

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SUBMISSION OF THE ONTARIO FEDERATION OF LABOUR

Appearances: D.B. Archer
D.F. Hamilton
H. Weisbach
J.F. Craighs
M. Lazarus

MR. ARCHER: On my far left is Morton Lazarus, Public Relations Director of the Ontario Federation of Labour; J.F. Craighs, Research Director of the Ontario Federation of Labour; I am David Archer, President; on my right is Douglas Hamilton, Secretary-Treasurer, and Henry Weisbach, Welfare Director.

THE CHAIRMAN: Thank you. If you wish to proceed?

MR. ARCHER: Thank you. Very quickly, Mr. Chairman, I will go through this. First of all, you had your picture taken with somewhere over 70,000 cards there, which are apparently cards signed by people from all parts of Ontario, supporting the position taken by the Ontario Federation of Labour on the question of medical care in Ontario, and they are over there in the corner. That's part of our campaign in order to provide what we believe should be adequate prepaid medical care for the citizens of Ontario.

As you know, the trade union movement has pioneered in this field in the Workmen's Compensation, and others, and we once again come before you. We have suggested to Dr. Glen Sawyer that we have said in our brief that we are

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MR. ARCHER: On my left is Morton Lasswell.

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1 merely re-stating what we have said on many other occasions.
2 Of course, that saves us the trouble of writing another brief.

3 On the first page of our brief you will find a
4 summary of what is contained in the rest of the brief. At
5 first our objections to Bill 163 as it now stands.

6 We hope when you make your report to the Govern-
7 ment you will take notice of our objections, and suggest to
8 the Government that changes might be made and modifications
9 and amendments to Bill 163 that would take care of the inade-
10 quacies that we think exist in that Act.

11 And, Mr. Chairman, we have noticed in the press
12 that there has been a tendency - at least we think so - on
13 behalf of some members of the Committee to restrict the breadth
14 of the inquiry of this Committee, and we don't think that
15 should be done. We think it should be the broadest type of
16 inquiry into all matters pertaining to health and medical
17 insurance, and we say that not having sat through the hearings,
18 relying only on press coverage, and realizing, sometimes
19 having been the recipient and the victim of both types of
20 press coverage, the inadequacy of such a statement on those
21 grounds.

22 We believe, quite frankly, there should be a
23 public, universal medical care scheme for the citizens of
24 Ontario, without regard to their station in life, the amount
25 of money they happen to earn, or own, and that this should



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1 include curative, preventive and all other forms of medical
2 care, and I don't think, Mr. Chairman, at this stage I can
3 say very much more than that.

4 Our real belief, and the belief of the people
5 we represent, is that we need, and should have, adequate
6 health care, which includes medical care, universally, for
7 the people of this province, controlled and operated by a
8 government agency, and not by private insurance companies.

9 I think that's the only opening statement I
10 want to make, Mr. Chairman.

11 THE CHAIRMAN: Thank you. You referred to the
12 I don't know how many thousand cards that you had with you
13 here. Would you mind letting our Secretary, Mr. Simpson, have
14 enough of these to distribute one each to the members of the
15 Enquiry?

16 To start our questions, Miss Reid.

17 MISS REID: I found your brief very clear and
18 concise, and I was interested also in your exhibits. Of
19 course, I didn't examine Exhibit C, but in your brief you refer
20 in a number of places to the group practice of medicine, and in
21 the summary here of your submission, the first page, you state
22 that Bill 163 makes no provision for the encouragement of
23 group practice.

24 Do you think that the Bill denies, or dis-
25 courages, group practice?

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1 MR. ARCHER: We believe that it might, for
2 instance, the type of group practice I suppose that may be a
3 bit of a misnomer, that we have established in Sault Ste.
4 Marie through the trade union movement for preventive health
5 care. We have a feeling that the Bill doesn't adequately
6 protect that type of approach to the health care of the people
7 of Ontario.

8 We aren't quite sure, there is no - certainly
9 no encouragement, I agree with that, but we're not quite sure
10 that the future of such a scheme as the Sault Ste. Marie
11 scheme might not be menaced by the wording in Bill 163, and
12 we want to be assured, and reassured if you can, that such
13 endeavours as the Sault Ste. Marie Clinic, and others that we
14 hope to start through the trade union movement, will not be
15 menaced or hampered in any way by this Bill.

16 MISS REID: Can you state specifically why you
17 think it discourages group practice, or probably, to put it
18 another way, how the Bill might encourage group practice, as
19 you feel it should be encouraged?

20 MR. CRAIGHS: Miss Reid, there's a distinct
21 possibility that such organizations as have been established
22 in Sault Ste. Marie would be excluded from the Medical Carriers
23 Incorporated, since this Bill purports to make them the only
24 group of carriers whereby a standard plan could be obtained.

25 There's no reassurance in the Bill as it's



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1 presented that they might not be excluded. In other words,
2 they could wind up in a position that they might be forced
3 to pay two premiums assessed against the medical carriers for
4 the distribution of the low-risk and the high-risk people, and
5 yet receive none of the benefits of being members of the
6 Medical Carriers Incorporated.

7 MR. MAJOR: Mr. Archer and gentlemen, I thought,
8 if my memory serves me, that we had cleared this up with the
9 Sault Ste. Marie Group Health Association, and that their
10 problem was one of trying to establish an amount per subscriber
11 for capitalization, an accounting procedure, rather than one
12 of principle.

13 Now, it's not the intention of this Bill to
14 make any special privilege for anyone as far as a carrier is
15 concerned, and I thought that when these chaps made their
16 presentation to the Enquiry that we had cleared this up, that
17 they were actually in the business of "selling" physicians'
18 services, that they were quite prepared to sell this to any
19 group in the City of Sault Ste. Marie and the surrounding
20 districts, provided that they were not called upon to sell
21 this to groups that were outside of their area of influence,
22 and, as I recall the discussion, this was more or less agreed,
23 that this was a reasonable approach, but on the basis of which
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25 also be required to assume a reasonable responsibility for



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2 out the Province of Ontario, some of them just as localized as
3 the Sault Ste. Marie group, and it was my impression that
4 there was nothing that would deter the Sault Ste. Marie group
5 being in Medical Carriers Incorporated, except the one item
6 that they were assessing by an accounting procedure.

7 MR. ARCHER: I talked to the Sault Ste. Marie
8 group, and I said that we would like to be assured, and
9 reassured, and they are still not quite convinced that it's
10 just as simple as you make it appear, Mr. Major, although I'm
11 willing to accept your explanation at this time, but we still
12 don't think that the Bill is clear enough in spelling out what
13 the trade union movement can do along the lines that we have
14 started to do in Sault Ste. Marie.

15 THE CHAIRMAN: I think, Mr. Major, we couldn't
16 give them an assurance that this is what is going to take
17 place, and this is not provided for in the draft of the Bill.

18 We can give them no assurance that this is the
19 way it will happen.

20 MR. MAJOR: No, Mr. Chairman. My impression,
21 after discussing this matter with the Sault Ste. Marie delega-
22 tion, was that there was nothing in this Bill that would deter
23 them from accepting whatever advantages or disadvantages were
24 inherent in the Bill with respect to carriers, other than one
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1 subscriber for a capital set-up, and if I remember correctly
2 this was in my mind reasonably well-resolved, that this was
3 still nothing but an accounting procedure, and as far as I'm
4 concerned, Mr. Archer, it may be that my impression is wrong ---

5 MR. HAMILTON: We would not want anything in
6 this Bill to put the Sault Ste. Marie practice in jeopardy.

7 MR. MAJOR: That's within reason of normal
8 practice.

9 MR. HAMILTON: Well, it all depends who is
10 talking about within reason. I simply say that we don't want
11 anything in this Bill to put the Sault Ste. Marie plan, or
12 any similar one, in jeopardy.

13 THE CHAIRMAN: I think that's a very good state-
14 ment.

15 MISS REID: On page 7 of Exhibit A, in the
16 preamble to your recommendations, in the last sentence you say:

17 "Campaign to have a government-sponsored
18 health care program implemented in stages ---"
19 Could you explain what you mean by implemented
20 in stages?

21 MR. ARCHER: Yes. I think there are principles
22 on which the trade union movement based its demand for a medical
23 prepaid health care scheme. Obviously, there's questions that
24 were in front of you a minute ago, osteopaths, and an extension
25 of the services named that could not be put into effect



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2 government sponsorship is there, we hope that we would build
3 on that to eventually have an all-inclusive health care plan
4 for the people of Ontario.

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6 didn't try and show any details, how much should go into the
7 first stage. A great deal would depend on the plan that was
8 in operation and the people who administer it as to how fast
9 they could go.

10 MISS REID: Another question occurred to me in
11 the brief to the Royal Commission on page 22, the Advisory
12 Council. I believe you explained the Advisory Council would
13 administrate.

14 MR. ARCHER: Either administrate or to advise -
15 it would be a council that would advise the administrative
16 body. I suppose the administrative body would be responsible
17 for administration and the Ministry would be responsible for
18 the introduction of legislative changes. If you have an
19 Advisory Council and it legislates changes I suppose it would
20 suggest to the Minister he should introduce them to the house.
21 The administrative body can't go further than determine administra-
22 tion changes and they make recommendations to the legislative
23 body. It is both, really, because the administrative body
24 can't make legislative changes. They are in charge of admini-
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1 to go to the administrative body, the Workmen's Compensation
2 body commission, and make administrative changes that are
3 satisfactory to both, although if you want to change the
4 Workmen's Compensation Act, then you must go to the Minister
5 and suggest legislative changes to him.

6 MISS REID: Thank you. My last isn't really a
7 question; it is just a comment. On page 4 of the brief, the
8 submission, you are speaking of the need to train professional
9 personnel, professional personnel, and speaking of nurses and
10 particularly male nurses, I quite agree with you, there is a
11 great need to attract more men into nursing and that there is
12 a place for men in nursing. I was wondering if you could docu-
13 ment the statement that oddly enough prior to the last one
14 hundred years most of the nursing was done by men in religious
15 orders. I wasn't aware of that.

16 MR. CRAIGHS: There is a lot of historical
17 reference to male nurses in religious orders. At the time of
18 the Crusades there was quite a number.

19 MISS REID: I realize that, but that is about
20 four or five hundred years ago. One hundred years ago I would
21 question whether most of the nursing was done by men in reli-
22 gious orders.

23 MR. HAMILTON: I think our problem boils down
24 to there are not enough today.

25 MR. ARCHER: I don't know when Florence

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1 Nightingale got started. You should know more about that than
2 I do.

3 MISS REID: Thank you, Mr. Archer.

4 THE CHAIRMAN: Mr. Coulter?

5 MR. COULTER: Thank you, Mr. Chairman. Gentle-
6 men, I have found the three articles I received quite interes-
7 ting. There are two or three problems that bother me a little
8 bit. I have come to the conclusion you are asking for a
9 complete comprehensive government-subsidized or government
10 paid-for or government-run plan; is that correct?

11 MR. ARCHER: I think that is fair. Not govern-
12 ment paid - we are willing to pay for it out of our contribu-
13 tions.

14 MR. COULTER: A government plan.

15 MR. ARCHER: A government plan I think would be
16 a better wording.

17 MR. COULTER: In that particular line, are you
18 suggesting that the medical profession become, then, civil
19 servants?

20 MR. ARCHER: Not at all, not at all.

21 MR. COULTER: That there be some way of working
22 it out so they do not become civil servants?

23 MR. ARCHER: Yes. But may I say very, very
24 quickly that being a civil servant is not a fate worse than
25 death. I am not apologizing that some people are civil



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1 servants. There was no thought in our minds that doctors would
2 become civil servants. I don't think it is necessary to the
3 implementation of the plan we have in mind.

4 MR. COULTER: Probably you are reading me wrong.
5 If this was a government-run plan then it would become neces-
6 sary, would it not, that medical doctors would have to become
7 civil servants?

8 MR. ARCHER: Why? The Workmen's Compensation
9 handles hundreds of thousands of cases. They have deals with
10 doctors, controlled and operated by the doctors, and the
11 doctors who work under that plan are not civil servants.

12 MR. COULTER: I just wanted to put it on the
13 record. Thank you very much. Another thing that bothers me,
14 if this were a government-sponsored plan and not sold by
15 insurance people these people who are in a union organization
16 and have a contract with either P.S.I. or a line company in
17 their negotiations whether you have totally paid for by your
18 employee or partly paid for by your employee, these would just
19 go out the window, would they not?

20 MR. ARCHER: We would negotiate it back. I
21 wouldn't worry about that, Mr. Coulter. The same question was
22 raised with regard to hospital insurance when we had to renego-
23 tiate our plans because of the introduction of hospital
24 insurance where the Government took over standard ward coverage
25 and it was considered to be quite adequate. We see standard

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2 people to provide for more than standard type care - I can't
3 think now what it would be, but we haven't any objections to
4 it being written by insurance companies such as the standard
5 ward coverage and semi-private and private and everything else
6 you want. The insurance companies write it. We have no
7 quarrel with that.

8 MR. COULTER: In your research or in any
9 research that you have done do you find that in any particular
10 communities there is a great shortage of, we will say, medical
11 doctors or health clinics and so forth?

12 MR. ARCHER: Well, I don't know - shortage is
13 not a good word. I say there is a disparity. If I had a
14 disease to be diagnosed I would rather live in Toronto than
15 any other part. If it was in all Canada, which is not within
16 your terms of reference, you could probably say, "Yes, there
17 is a shortage." I think it might be used in parts of Ontario.
18 I think the doctors might admit there is a shortage of medical
19 services in some parts of Ontario. I am not quite sure what
20 the remedy would be if you are going to ask me the next ques-
21 tion. I will answer it before you get to it.

22 MR. COULTER: I had one other question I wanted
23 to ask. It has left me at the moment. It may come back later
24 and I will put it.

25 THE CHAIRMAN: Fine. Dr. Butt?



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1 DR. BUTT: Thank you, Mr. Chairman. I was
2 very interested in your comments about group practice. I am a
3 little bit interested to know just what you mean. I know what
4 you mean by your clinic because you have that in there
5 precisely. Group practice, is it three or four obstetricians
6 and they are group, are they not?

7 MR. ARCHER: I think so.

8 DR. BUTT: A consultant working with a general
9 practitioner is a group. Another thing I was wondering, what
10 happens to the case where a doctor, say, within a group wishes
11 the opinion, or perhaps the actual surgery done by somebody
12 outside of that group in which group you are talking about
13 there is a qualified surgeon in terms of our Act and in terms
14 of your definition?

15 MR. ARCHER: I don't know, sir. You are getting
16 technical.

17 DR. BUTT: I am not being technical because Mr.
18 Hamilton, I believe, stated you wanted nothing to interfere
19 with this group.

20 MR. HAMILTON: I don't think I said that, sir.

21 DR. BUTT: It will be in the record. What did
22 you say?

23 MR. HAMILTON: I said our position was clear.
24 We don't want this Act to disturb the group practice that we
25 have.

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1 DR. BUTT: Already set up?

2 MR. HAMILTON: Yes.

3 DR. BUTT: Fine. Coming back to what I stated.
4 What happens in this specific instance? I am talking about
5 the practice of medicine. What do you do? Have you any
6 ideas?

7 MR. HAMILTON: I would think in any group prac-
8 tice, talking about it in its broadest terms now.

9 DR. BUTT: I am talking specific terms.

10 MR. HAMILTON: Pardon?

11 DR. BUTT: Specific terms; specifically I am
12 asking you what would happen if a general practitioner within
13 your group decides that such-and-such a doctor outside the
14 group should do the surgery?

15 MR. HAMILTON: If they decided that, they would
16 go to him and have him do it.

17 DR. BUTT: That is all there is to it as far as
18 your group is concerned?

19 MR. SIMON: For the record that was told us last
20 week.

21 DR. BUTT: Thank you. It must be for the
22 record when we start debating at the head table. I prefer that
23 not to happen. The fact remains they don't stay within the
24 sphere of the members of the staff. Another thing I would like
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1 this group?

2 MR. ARCHER: That is correct.

3 DR. BUTT: The doctors are on the Board, voting
4 members?

5 MR. ARCHER: Sure.

6 DR. BUTT: That is the main thing about the
7 group part. I wonder, regarding your indictment on nurses
8 which went on and on from 16 to 20 of your brief on page 4.

9 MR. ARCHER: Our what?

10 DR. BUTT: Your indictment; this shortage, a
11 shocking indictment of our society that these people are
12 invariably, if not the lowest paid, among the lowest paid
13 compared with any other profession in Canada.

14 MR. ARCHER: I don't think it is an indictment
15 of the nursing profession. It is an indictment of our society
16 that it happens.

17 DR. BUTT: I was going to ask you, you have the
18 O.H.S.C., a particular profession or hospital and it is under
19 the Government. Is this what you say?

20 MR. ARCHER: I think so.

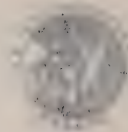
21 DR. BUTT: Then you make this statement as well.

22 MR. ARCHER: Yes.

23 DR. BUTT: Is there no incongruity in the two?

24 MR. ARCHER: Not at all.

25 DR. BUTT: I see.



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DR. BUTT: Is there no inconsistency in the two?

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1 MR. ARCHER: The fact is it took place over
2 many years and now we have the O.H.S.C. and we are having
3 trouble there, too, because of the philosophy of the O.H.S.C.
4 that we could remedy this condition, but at least the O.H.S.C.
5 has only had a few years in which to make the necessary
6 changes. Somebody says one hundred years and somebody else
7 says four hundred - I don't know, that there has been behind
8 that when private enterprise, if I can put it that way, had
9 hold of the whole thing. They were the ones that are respon-
10 sible, not O.H.S.C. That has only been in business a few
11 years.

12 DR. BUTT: What about England; the nurses can
13 still go on strike; isn't that correct?

14 MR. ARCHER: I suppose they do. I don't know.
15 They should hold a strike in Canada if they want.

16 DR. BUTT: That is your suggestion for carrying
17 on the profession?

18 MR. ARCHER: I don't suggest anything. There is
19 no law in Canada that says they can't.

20 DR. BUTT: That is correct. I think probably
21 we have got down to the fundamental: do you feel unions should
22 be under government trusteeship?

23 MR. ARCHER: No.

24 DR. BUTT: Thank you. That is all.

25 THE CHAIRMAN: Mr. Major?



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DR. BUTT: Thank you. That is all.



1 MR. MAJOR: Just to clear up, this \$2 an hour,
2 is that an unreasonable wage for a nurse?

3 MR. ARCHER: I don't think it is enough. I
4 don't know. Is that what nurses get?

5 MR. MAJOR: You don't think it is enough?

6 MR. ARCHER: No, it is not enough.

7 MR. MAJOR: Coming back to the question which
8 Miss Reid asked you referring to page 3 of the Sheraton-Brock
9 meeting.

10 MR. ARCHER: Where is that?

11 MR. MAJOR: Page 3. It is referred to on the
12 second paragraph of page 3 of your brief and it is also on
13 page 7 of the Sheraton-Brock meeting. I would like to clarify
14 something because it is very important to this Enquiry that we
15 know exactly, particularly in respect to the statement at the
16 bottom of page 5, the last sentence in the second last para-
17 graph on page 5 of your Sheraton-Brock report. This Enquiry
18 has got to find a starting point. There is a great deal of
19 material in your presentation. I would like to commend you on
20 various parts of it. Maybe to start this off you will refer
21 to page 4 of your Sheraton-Brock report where you say, in
22 essence, with regard to cost, we can't afford not to pay them.
23 I will accept your opinion on that at the present time, but we
24 have got to find a launching pad. I would gather, on page 3
25 of this, and page 3 of your brief itself, your approach is



MR. MAJOR: Just to clear up, this \$2 an hour,

is that an unreasonable wage for a nurse?

MR. ARCHER: I don't think it is enough. I

don't know. Is that what nurses get?

MR. MAJOR: You don't think it is enough?

MR. ARCHER: No, it is not enough.

MR. MAJOR: Coming back to the question which

Miss Reid asked you referring to page 3 of the Sheraton-Brock

MR. ARCHER: Where is that?

MR. MAJOR: Page 3. It is referred to on the

second paragraph of page 3 of your brief and it is also on

page 7 of the Sheraton-Brock meeting. I would like to clarify

something because it is very important to this Brady that we

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of this, and page 3 of your brief itself, your approach is



1 that we make a beginning.

2 MR. ARCHER: Yes.

3 MR. MAJOR: I don't know what is in the mind of
4 government. I would assume because of Bill 163 the Government
5 is saying, in my language, "We want a launching pad and here
6 is our launching pad." We also want a program. Do you think
7 Bill 163 is a reasonable launching pad? Never mind one year
8 or five years or fifteen years from now from the launching pad
9 - even though you say we can't afford to be without it, would
10 you think Bill 163 would form the basis of a reasonable
11 launching pad?

12 MR. ARCHER: No, sir.

13 MR. MAJOR: How far now do you want this
14 launching pad to go?

15 MR. ARCHER: I want the launching pad, if you
16 are going to use that terminology, I want the launching pad
17 to have the missile pointed in the right direction. I want it
18 to start off with government and government sponsorship of the
19 scheme, universal coverage for the people of Ontario. Limiting
20 the coverage is what I mean by a piecemeal approach. I don't
21 believe Bill 163 satisfies what the trade unions believe to be
22 the necessary beginning to a universally-covered, government-
23 controlled scheme. I think that is the best answer I can give
24 for the question. Obviously, we differ, but we differ
25 honestly.



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1 MR. MAJOR: I hope so. All right.

2 MR. ARCHER: I would hope not.

3 MR. MAJOR: Talking of insurance you say on
4 page 5:

5 "These people are in the long run more
6 dangerous opponents than the doctors
7 themselves."

8 I think this is a good point, the statement you
9 have just made. My question could be: why do you believe this
10 should be government-controlled rather than open to the
11 industry, and in relation to that last sentence can you tell
12 me why you want it this way?

13 MR. ARCHER: I suppose what we really must say
14 is we want the profit motive taken out of health care for the
15 citizens of Ontario. That is basic. That is the philo-
16 sophy with which people honestly disagree. We have done the
17 necessary research as to the costs. We could debate all day
18 about it, bandy the figures backwards and forwards. It is an
19 honest difference in philosophy. We believe that the health
20 care of our citizens should not be subjected to the needs of
21 private profits, that it should be the responsibility of the
22 Government to see that the health needs of our people are
23 looked after. I can't add more than that. It is our philo-
24 sophy.

25 MR. MAJOR: It is a good answer because you have

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MR. ARCHER: I would hope not.

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MR. MAJOR: It is a good answer because you have



1 cleared up one point. If you differ with this statement please
2 let me know. You haven't made any statement in respect to the
3 fact you think administration by government would be any more
4 efficient than administration by any individuals?

5 MR. ARCHER: No. I would say that administra-
6 tion, the cost of administration might differ materially, but
7 administration as such could be done by people, the type of
8 people you use on your administration. In fact, that is what
9 the Blue Cross did, as I remember, in the taking over by the
10 O.H.S.C.

11 MR. MAJOR: That is correct.

12 MR. ARCHER: So the administrators don't matter.

pw 13 MR. MAJOR: Now, then, if there was some
14 arrangement made here where there would be beyond a shadow of
15 a doubt no possible price whatsoever in Bill 163, would you
16 then have any positive antagonism on this being on a carrier
17 basis rather than government?

18 MR. ARCHER: I think it is an academic question.
19 I do not see why a private insurance company, a private carrier,
20 would take on this kind of responsibility.

21 If I were the general manager of an insurance
22 company, I would not do it either. It is purely academic.

23 MR. MAJOR: We had a presentation this morning
24 from the United Church people - I forget the name - it was from
25 the United Church Council in which they said there is enough



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1 people in this world to have an interest in other citizens
2 without any problem, and I suggest there are.

3 MR. ARCHER: I am positive there are many citi-
4 zens. There is no organization set up on a private motive for
5 the purpose of making profit. There is no reason that we
6 should. It is not desirable they should.

7 MR. MAJOR: There is always a first time. And
8 this may be it.

9 MR. ARCHER: All right, I will answer the ques-
10 tion when it happens.

11 MR. MAJOR: Mr. Archer, on page 4 of your
12 Sheraton-Brock Hotel production, the second paragraph; the
13 question has been asked of this Enquiry on previous occasions
14 that some of these broad comprehensive approaches could have
15 an effect - five or six hundred million dollars worth of bills
16 on the books. I think in your language and in my language and
17 in the language of any individual this is a big chunk of money
18 to absorb into society..

19 MR. ARCHER: Yes.

20 MR. MAJOR: This five or six hundred million
21 dollars is approximately 25% of the total earnings of the
22 industry of the Province of Ontario. Do you think that this
23 could, in any way, affect the economy of the Province of
24 Ontario and particularly in respect to some kind of business
25 recession? Do you think we would be broke, or should we take



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in the language of any individual that is a big chunk of money

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MR. ANCHER: Yes.

MR. MAJOR: What five or six hundred million

dollars is approximately 2% of the total earnings of the

industry of the Province of Ontario. Do you think that this

could, in any way, affect the economy of the Province of

Ontario and particularly in respect to some kind of business

recession? Do you think we would be broke, or should we take



1 this in block stages?

2 MR. ARCHER: I do not think I can answer that
3 question. All I can say is that other countries throughout
4 the world, Sweden, Great Britain, and others, have taken this
5 kind of approach to medical health care and they are not broke
6 and not likely to go broke. It would seem to me people them-
7 selves would be willing to pay - it is not simply taking this
8 much money out of circulation. A great deal is being paid
9 into private insurance companies and what we consider inade-
10 quate medical care. I think there is a difference between
11 what is now being paid and what would be needed extra to
12 provide the type of care we want.

13 I do not think it is enough for the richest
14 province, the Province of Ontario, to go broke.

15 MR. MAJOR: You missed my point. You must
16 remember that the National Health Services which was approved
17 in 1911 - there was a long period of transition.

18 What I want to get is, you as an official repre-
19 senting a great number of labour people in the Province of
20 Ontario, I cannot believe you would be in agreement to make a
21 drastic change and to throw it into a transition period that
22 might cause a great deal of economic problems and dissension
23 for the Province of Ontario. How fast this can travel without
24 getting us into trouble. You consider an ultimate proposition,
25 comprehensive health services of five or six hundred million



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1 dollars. How fast do you think we should do this? Is it five
2 years or ten years or six months? Would you have something
3 reasonable in your mind?

4 I know this is a snap decision you have to
5 make.

6 MR. ARCHER: I have not any idea. I will
7 answer the question as I did before. I feel much happier if
8 a plan was being launched on what we consider sound principle
9 of comprehensive universal coverage and government control
10 and operation. Then, I would be willing to talk about the
11 speed.

12 If it does not start off on that basis, I think
13 it is starting off on the wrong basis. I do not think it is
14 satisfactory. I do not think I can answer any better than that.

15 MR. MAJOR: You were not in here this morning?

16 MR. ARCHER: No.

17 MR. MAJOR: We had a discussion on health educa-
18 tion, and how far it should go. We pointed out, in my ques-
19 tioning, that there is a tremendous area and it is dubious how
20 far we should go. You are in agreement with basic health
21 education?

22 MR. ARCHER: Yes.

23 MR. MAJOR: I want to compliment you because in
24 your brief, and I have asked this question from at least two
25 delegations, you have outlined what you think is a good basis

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MR. MAJOR: I want to compliment you because in your brief, and I have asked this question from at least two



1 for group practice.

2 MR. ARCHER: Yes.

3 MR. MAJOR: A lot of people found this a little
4 difficult to answer.

5 Coming back to a question Miss Reid asked you
6 on page 22, if I recall it ---

7 MR. ARCHER: Which one are you on now?

8 MR. MAJOR: The blue one. The Advisory Council.

9 Are you acquainted with the details that were
10 presented by the Canadian Health Insurance Association Advisory
11 Council?

12 MR. ARCHER: No, sir.

13 MR. MAJOR: Your Advisory Council appears to me
14 compatible to what they suggested. There is an Administration
15 Board to the Medical Services Incorporated and the Canadian
16 Health Insurance Company. There would be an Advisory Council
17 which would act as a policy board. This policy board would
18 have proper and equitable representation for the consumer.

19 Is this the type of thing you have in mind?

20 MR. ARCHER: I am worrying about the word
21 "policy." How far would the policy go - Advisory Council
22 could make policies?

23 MR. SIMON: The Medical Association suggested
24 the consumer representation on the Advisory Board, not the
25 insurance people.



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1 MR. MAJOR: Regardless of who takes credit for
2 it, there should be an Advisory Council above the Board of
3 Administration for Medical Services Incorporated. This
4 Advisory Board could handle all, and it would be the liaison,
5 the connecting link, between government and carrier.

6 MR. ARCHER: If you are talking about the
7 Ontario Medical Association here, I know that one. I am
8 afraid they want a committee that is composed of nine people:
9 three from the Medical Association, three from the medical
10 carriers, one civil servant, and two to look after the public
11 interest. I consider this a pressure group and not an Advisory
12 Board.

13 MR. MAJOR: I am only talking of principle.
14 The Advisory Board has been suggested at least by two organiza-
15 tions, and you come along with another.

16 MR. ARCHER: Yes.

17 MR. MAJOR: Let us boil this down. I suggest
18 this Advisory Board would be the policy-making board with
19 proper and equitable consumer representation on it. Is this
20 the type of board you feel is necessary?

21 MR. ARCHER: I do not think it can be policy-
22 making, sir.

23 MR. MAJOR: Can you delineate what you want
24 your Advisory Board here to do?

25 MR. ARCHER: I want it to be a liaison between



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1 the consumer and doctors and others who are interested in
2 this and the administration so the administration does not
3 become bureaucratic and can also be consulted by Ministers
4 for necessary legislative changes.

5 I do not want too many people who can make
6 administrative or legislative policies because I think of the
7 saying of too many cooks spoiling the broth.

8 MR. MAJOR: You agree with what I say and I
9 agree with what you say.

10 MR. ARCHER: If you said what I think you are
11 saying, I agree.

12 MR. MAJOR: On page 14, Article 6:

13 "Group practice is easily supervised and
14 quality controls maintained by responsible
15 medical boards."

16 I have two questions of this. First of all,
17 what do you say is the composition of a responsible medical
18 board and where do you get the individuals to make up the compo-
19 sition?

20 MR. ARCHER: I do not think there was any inten-
21 tion with other than a responsible medical board as it is now
22 constituted.

23 MR. MAJOR: How do you mean as now constituted?

24 MR. ARCHER: I think supervised as far as a
25 practitioner's point of view by the Medical Association itself.

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1 I have no desire to interfere with practical medicine. I hope
2 the doctor will stop interfering with the practice of trade
3 unions.

4 MR. MAJOR: We are not talking about responsible
5 medical groups.

6 Coming down to page 15, the last sentence on
7 page 15:

8 "---there was a very close similarity of
9 percentage of national income spent on
10 medical care ---"

11 First of all, I want to know what you mean by
12 national income and I want to know what you mean by medical
13 care.

14 MR. ARCHER: I think at this point I have to
15 turn this over to Research for the definition of these terms.
16 I assume that it is gross national income.

17 MR. MAJOR: Gross national profit?

18 MR. ARCHER: Yes.

19 MR. MAJOR: "Medical care" - do you mean this
20 in its broadest sense - drugs, everything?

21 MR. ARCHER: Yes.

22 MR. MAJOR: All the health services you can
23 think of?

24 MR. ARCHER: Yes.

25 MR. MAJOR: I have done a bit of calculation on



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1 these statistics that you have set forth at the bottom of
2 page 15 and 16, particularly on page 16, and have tried to
3 arrive at a cost for a physician in the Province of Ontario,
4 everything being equal. This would cost us approximately
5 \$276 million a year to look after the citizens; that is, men,
6 women and children of this province.

7 I am not going to guarantee this, but it is the
8 reasonable approach from a statistical average standpoint.
9 You do not have any figures for all the rest - what can I add
10 to this to fulfil your term of medical service?

11 MR. CRAIGHS: You have to make yourself a little
12 plainer.

13 MR. MAJOR: I only know what is in my life.

14 MR. CRAIGHS: All I can say is my figures would
15 be as good as yours.

16 MR. ARCHER: What you are suggesting is all
17 other medical care costs - talking to my colleagues at this
18 stage of the game, I do not know if it is material to this
19 Committee that those figures be given to them. We will tell
20 our Research Department to get them and we will send them to
21 you.

22 THE CHAIRMAN: Are you reading that 4.41% of
23 gross national product equals so much and you know what the
24 physicians' services cost, so it is the difference between
25 those? Can you give us the difference? Do you know what 4.41%



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THE CHAIRMAN: Are you reading that \$4.4% of

gross national product equals so much and you know what the

physicians' services cost, so it is the difference between

those? Can you give us the difference? Do you know what \$4.4%



1 of the gross national product would cost?

2 MR. MAJOR: Eight hundred billion dollars.

3 THE CHAIRMAN: That is 4.41?

4 MR. MAJOR: Yes.

5 Have you any figures that we can check the 4.41?

6 I think you made a fine suggestion that your Research Depart-
7 ment bring this down. Never mind the I.L.O. Do this from an
8 Ontario standpoint.

9 MR. ARCHER: We will try.

10 MR. MAJOR: On page 17, again on the Royal
11 Commission presentation, as a matter of interest you say:

12 "We do not consider that the fee-for-service
13 basis is the best, either for the doctor or
14 for the patient."

15 And further on you say:

16 "We do not claim that the salary system of
17 payment is perfection, but what we do say
18 is that it is the best in terms of the
19 Ontario situation."

20 I spent a couple of hours the other night on
21 this and I must admit I could not figure out exactly how you
22 arrived at the fee-for-service basis is not the best for either
23 the doctor or patient, and for the Province of Ontario as a
24 particular statement that the salary system would be the best
25 for the general practitioner.



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the doctor or patient, and for the Province or Ontario as a

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for the general practitioner.



1 How do you arrive at this sort of thing?

2 MR. ARCHER: I think it is stated in the brief,
3 sir, that we believe that doctors should be well paid. We are
4 not opposing particularly the fee-for-service basis of payment.
5 It is widespread. We do not believe it is necessarily the best
6 payment. It is a hit-and-miss payment.

7 I hear doctors telling us of how many times
8 they are not paid. A substantial salary, of which a doctor
9 was assured, for instance might attract doctors to the out-of-
10 way areas which I think Mr. Coulter questioned me about. I
11 know we are saying here that this is complete and utter dedica-
12 tion to the fee-for-service is one of the things that makes it
13 difficult to have a dialogue with doctors in which we both
14 talk the same language.

15 THE CHAIRMAN: I do interpret your brief here
16 definitely and specifically as that you feel that the salary
17 basis is preferable to the fee-for-service basis.

18 MR. ARCHER: From my point of view, I think so.

19 MR. MAJOR: I look for some logic behind it.

20 I cannot say that the United States should not
21 be spending seventy-five billion dollars a year getting to the
22 moon.

23 MR. ARCHER: It would be an opinion.

24 MR. MAJOR: Is this your offhand opinion?

25 MR. ARCHER: No, not my offhand opinion.

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How do you arrive at this sort of thing?

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/dpw 1 It seems to me, sir, a fellow with an assured income is better
2 able to plan and do things that he has to do and it is a better
3 method of payment than the fee-for-service or the hit-and-miss
4 system of just what you get from hour to hour or day to day.
5 It's as simple as that. Maybe the doctors would sooner have
6 the fee-for-service, I don't know. As I understand it, there
7 was a tremendous per cent of the doctors in this country who
8 are on a salary basis and enjoy it quite well.

9 MR. MAJOR: There are quite a number in private
10 practice of medicine at large. I understand that the doctors
11 in Saskatchewan and the doctors in England have never been so
12 well off and yet are you going to destroy our fee-for-service
13 basis in the Province of Ontario so that the doctors could
14 make more money? Are you willing to realize this objective
15 may be the answer? This condition may be the result of our
16 program?

17 MR. ARCHER: I don't think it would be, sir. I
18 am not willing to admit that would be the result. I don't
19 think it would abolish a fee-for-service either in Great
20 Britain or in Saskatchewan so I don't know how you can arrive
21 at your conclusion.

22 MR. MAJOR: I think you are right. There is a
23 great deal of salaried doctors in Great Britain. To some
24 extent I think you are right. The very fact that they put
25 this proposition up as a State-sponsored plan has cost a lot

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1 of money. It is bound to cost a lot of money because the
2 doctors are earning more than they did before.

3 MR. ARCHER: I have no objection to that, sir.

4 MR. CASWELL: I wonder if Mr. Archer was aware
5 that when the Sault Ste. Marie group appeared before us the
6 Director of Medical Services was very emphatic in answering the
7 question to the fact that the doctors there were not working
8 on salary.

9 MR. ARCHER: That may well be, sir. I accept
10 your word for it. I don't know if that is so. I don't doubt
11 it.

12 MR. MAJOR: Mr. Archer, on page 21, under the
13 paragraph on administration, the second line you say:

14 "Our principal concern is to oppose any
15 system of administration which would place
16 control in the hands of one interested
17 group."

18 Now I don't know how to overcome this. I don't
19 know. Can you tell me how? Sooner or later doesn't some
20 group control this? The Advisory Committee of government,
21 the medical profession? Just what are you getting at?

22 MR. ARCHER: I think it is obvious, sir, to
23 everybody else on the panel that we are saying that one
24 interested group, I think we are talking of occupation of
25 groups, by interested groups, we are saying it should not be

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1 the doctors themselves or simply the civil servants but that
2 the administration be in the hands of the representative group
3 of people. I don't think it means anything more than that.
4 Certainly we never intended it to mean more than that.

5 DR. BUTT: What do you mean by a representative
6 group of people? What do they represent?

7 MR. ARCHER: I think, for instance, there are
8 consumers, very interested group, that should be represented
9 on any administration.

10 DR. BUTT: Specifically who would be the
11 consumer? Are you talking about a housewife?

12 MR. ARCHER: Might very well be.

13 DR. BUTT: What about the Government; is that
14 not a consumer?

15 MR. ARCHER: I think the Government could be
16 represented on such a panel.

17 DR. BUTT: Thank you. I just wanted to under-
18 stand what you were thinking of.

19 MR. ARCHER: I am not thinking purely in terms
20 of representation by labour. Labour as such might not be
21 represented, but I would do my best to see that they were, sir.

22 DR. BUTT: That is a fair statement.

23 MR. MAJOR: I gather, on page 21, the second
24 last line in paragraph 60 should have been lay instead of
25 law?



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last line in paragraph 60 should have been lay instead of



1 MR. ARCHER: Yes, I would think so. I would
2 think lawyers can be represented on this committee.

3 MR. MAJOR: I gather from your statement on
4 page 23, paragraph 2, in the middle of the paragraph, that
5 you would have no particular sympathy with any type of patient
6 participation in respect to a health plan?

7 MR. ARCHER: I don't follow you, sir.

8 MR. MAJOR: Patient participation in my termi-
9 nology is along the line of some place the fellow who is going to
10 get the service, must pay something to that service out of his
11 pocket.

12 MR. ARCHER: The fellow who is going to get the
13 service pays for it in one way or another; just a matter of how
14 they pay.

15 MR. MAJOR: I am talking about direct.

16 MR. ARCHER: Not for basic service. If he
17 wanted anything else than would be provided in the initial
18 stages, perhaps some place down the line, everything would be
19 provided, but basic service I don't think he should be asked to
20 pay for except through taxation or contribution.

21 MR. MAJOR: All right. Now, then, there isn't
22 any status of society that hasn't got some villain so now this
23 being so should there be any privilege in respect to carriers
24 or the Government, Commission, whoever is going to be respon-
25 sible for this, in respect to, say, the administration set-up -

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1 paragraph 60, should these people have any control over the
2 billings?

3 MR. ARCHER: Now, let me see if we understand
4 each other. By the billings you mean the cost of the service?

5 MR. MAJOR: That is right.

6 MR. ARCHER: Should who be in control?

7 MR. MAJOR: We have got a law here that says
8 you must not commit murder.

9 MR. ARCHER: But we still do.

10 MR. MAJOR: People are punished if they commit
11 murder. Now we are going to, without any participation by the
12 public, getting it free, as a matter of fact, directly but
13 indirectly they are paying for it and somebody has committed
14 murder on the service, should the carrier or the Commission
15 or whoever is in charge of this have any power to put this
16 fellow on the carpet?

17 MR. ARCHER: I would think so. I would think
18 the schedule of fees - I am not sure I agree with the method
19 of arriving at the schedule of fees. If I could do that for
20 trade unions, they would be the highest-paid people in the
21 world. The schedule of fees is set by the Medical Association,
22 and if someone is gouging, I will use somebody else's words
23 over here, I think they would have to be brought to task. It
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1 MR. MAJOR: Same application to citizens.

2 MR. ARCHER: You may have a citizen, say,
3 abusing the privilege. This would be much more difficult,
4 not quite as black and white, I don't think privileges should
5 be abused, and I think it would be up to the doctors themselves
6 - this would be a medical decision I think that might have to
7 be made rather than a decision made by a lay body as to whether
8 or not the privileges were being abused and it would be a
9 doctor who surely would have to make a decision on that, I
10 would think.

11 MR. MAJOR: Okay; we have the Jones family. The
12 Jones family over a period of a year never had any office
13 calls, two children, and everything is home calls. Home calls
14 include preventive medicine up to treatment of acute condition
15 and the doctor gets his telephone call to come to the home.
16 He doesn't know whether it is an acute condition or for an
17 inoculation. What do we do about it?

18 MR. ARCHER: I don't know very much you can do
19 about it. I would think there would not have been a great
20 abuse of the privilege in other areas to have shown there is
21 not any greater abuse of the privilege under this new scheme,
22 whatever it may be, than exists at the present time. I think
23 it would be a medical question. The first call, perhaps the
24 doctor would have to go. I think the doctor could answer this.
25 This doctor would have to go to find out what was wrong. From



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1 there on in he could decide what he wanted them to do. I
2 wouldn't want to interfere if I were on this Commission with a
3 doctor's right to say what should be done under those circum-
4 stances. I think I would be willing to be guided by the
5 recommendation.

6 MR. MAJOR: I submit, Mr. Archer, the doctor
7 hasn't got an answer for us and he has got to answer the tele-
8 phone. What I am trying to clarify is the union's approach
9 as to whether or not there should be any kind of arbitration
10 procedure set up whereby the citizens can be judged guilty of
11 abuse as well as the medical profession. I can't see this is
12 a one-sided affair. It is not a one-way street. This has got
13 to be a two-way street and you know what will happen? The
14 citizen calls the doctor and he goes or doesn't go, but this
15 citizen who is repetitively calling the doctor ---

16 MR. HAMILTON: Can you find anything in our
17 document that indicates to you we are proposing a one-way
18 street?

19 MR. MAJOR: I think your whole intent here is
20 to leave the citizens so free that even the Lord himself could
21 not chastize him if he was a villain and this is not quite
22 right because we do have a certain percentage of citizens who
23 have to be kept a bit under the thumb, to be reasonable with
24 them.

25 MR. ARCHER: Presumably one answer to it, and



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1 again it is a difference of approach, lawyers have a saying
2 that hard cases make bad law and if there are citizens like
3 this, I think it would be so very much in the minority that
4 I would sooner we put up with them and gave the necessary
5 services to the great bulk of our people. This might be, I
6 don't know, a hardship that we have to put up with. I would
7 hope in some way you can handle it. I am not willing to make
8 the Medical Services Act in Ontario conditional on what I think
9 very, very few people would take advantage of.

2 10 MR. MAJOR: I think maybe the question was an
11 unfair question but experience, possibly, is the only thing
12 that helps us in this area and we do know, under certain condi-
13 tions, if you let one person get away with it, all the neigh-
14 bours try and get away with it. Therefore it is necessary for
15 a reasonable degree of prudence, that reasonable men should
16 put in here some kind of clause to control this and then exer-
17 cise the right of that clause on a discretionary basis with
18 arbitration being there if it is necessary.

19 MR. ARCHER: I won't quarrel with the principle
20 If you show me what it is you are drawing up, I will be glad to
21 criticize it or analyze it at that time. I realize it is a
22 difficulty. I don't know the answer.

23 MR. MAJOR: Thank you, Mr. Chairman. Those are
24 all my questions.

25 THE CHAIRMAN: Mr. Mulrooney?



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1 MR. MULROONEY: Thank you, Mr. Chairman. I am
2 a little concerned with certain aspects of the Sault Ste.
3 Marie group practice situation. If the Sault Ste. Marie
4 people under this Bill were considered carriers, the Bill
5 provides that they must underwrite guaranteed renewable stan-
6 dard contracts to any person who applies. Now, I wonder if
7 you would consider, if an arrangement could be made with
8 another carrier and one carrier at least would be willing to do
9 this, any application of that sort of thing - some of their
10 people may move out of the area and they could not continue
11 coverage there; a matter of providing standard contracts that
12 are non-cancellable could be something of a problem there.

13 Under the Act as it is written, would you
14 consider that provision as a method of taking care of this
15 problem would solve at least part of their problem?

16 MR. ARCHER: I certainly consider it, sir.
17 Have to be considered, of course, with the Sault Ste. Marie
18 people themselves as a board and whether it would solve the
19 problem or not, I would have to give it more consideration
20 than I can just on the spur of the moment. It is a suggestion
21 worthy of consideration.

22 MR. MAJOR: You realize, Mr. Archer, the Bill
23 in its present formula would not permit this?

24 MR. ARCHER: Yes.

25 MR. MAJOR: The Bill in its present formula

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1 would permit transfer. Transfers are a very simple procedure;
2 have been handled across North America and even between here
3 and Australia without any difficulty. It would not permit a
4 carrier to pass on his liability for satisfying this Bill to
5 another carrier under the present circumstances.

6 MR. MULROONEY: That is all, thank you, Mr.
7 Chairman.

8 THE CHAIRMAN: Any other questions?

9 MR. CASWELL: I am a little concerned, Mr.
10 Chairman, with one statement that I thought Mr. Archer made
11 at the beginning, or suggestion that you made that the Enquiry
12 was restricting or appeared to be restricting presentations
13 being made. Is that the impression I got, sir?

14 MR. ARCHER: I think I qualified it as much as
15 I could from reading newspaper reports. That seemed to be the
16 feeling that had been left by the newspapers. I must admit
17 that after the searching questions to which I have been
18 subjected to here - I am very glad. I don't mean that in a
19 derogatory sense at all - I think I would withdraw those
20 remarks.

21 MR. CASWELL: I think this is one thing we have
22 endeavoured to be extremely careful about, to see unlimited
23 time is given to everyone. That is what made me wonder.

24 MR. ARCHER: I would not quarrel with that.

25 THE CHAIRMAN: Mr. Whitney?



MR. MURPHY: That is all, thank you, Mr.

Chairman.

THE CHAIRMAN: Now, Mr. Caswell.

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THE CHAIRMAN: Now, Mr. Caswell.



1 MR. WHITNEY: I think, Mr. Chairman, we should
2 have a few remarks on the petition that has been brought in
3 so we will just know what weight to give to it more than in
4 just a general sense. Could you tell us, for instance, how
5 you picked up this petition and what material you gave to
6 people before they signed?

7 MR. ARCHER: Yes, sir, very glad to. This
8 little yellow book that Mr. Major was calling the Sheraton-
9 Brock report, which suits me.

10 MR. CASWELL: Suits the Sheraton-Brock, too,
11 sir.

12 MR. ARCHER: This was presented in resolution
13 form to our convention which represents delegates from every
14 nook and cranny of Ontario; somewhere in the neighbourhood of
15 1,000 delegates. They passed this whole booklet after much
16 debate and instructed us to carry on a campaign for the type
17 of medicare that is outlined in this little booklet. Thousands
18 of these yellow booklets, leaflets, I am sure - I don't know
19 whether they are on record. If they are not we would be very
20 glad to make up a kit for each member of the Committee if they
21 so desire - went to all the local unions, labour councils
22 and other interested bodies.

23 We got requests from most unusual people or
24 groups but we sent these kits out. There was a kit made up
25 and with the kits went as many of these cards as they felt was



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We got requests from most unusual people or groups but we sent these kits out. There was a kit made up and with the kits went as many of these cards as they felt was



1 necessary and they signed them and returned them to us. Now,
2 basically, that is what happened. If you want any more
3 detail I would be glad to answer but that is the way the
4 campaign was conducted.

5 MR. WHITNEY: And the campaign followed shortly
6 after the approval at the convention; is that the way it was
7 done?

8 MR. ARCHER: Yes, sir. We are sorry we haven't
9 a great deal more than that but unfortunately both governments
10 decided to hold elections which interfered with our medicare
11 campaign. While we were getting cards our people were invol-
12 ving themselves in two election campaigns: one federal and one
13 provincial on behalf of various political parties.

14 MR. WHITNEY: The reason I ask the question is
15 I notice there November 5th, 6th and 7th, 1962, and I think
16 for the record we should probably know just about what months
17 and then what year the petition was done.

18 MR. ARCHER: Perhaps the Secretary-Treasurer
19 would answer this.

20 MR. HAMILTON: Be following November, be
21 December-January, I would think, of 1963. Just following the
22 convention. I might elaborate a bit on that because when you go
23 to a delegate convention a lot of times things are said about
24 the feeling of the people in the field towards certain problems
25 and we sent cards out to see if there was widespread appeal for

necessary and they signed them and returned them to me. Now, basically, that is what happened. If you want any more detail I would be glad to answer but that is the way the campaign was conducted.

MR. WHITNEY: And the campaign followed shortly

after the approval at the convention; is that the way it was

done?

MR. ARCHER: Yes, sir. We are sorry we haven't

a great deal more than that but unfortunately both governments decided to hold elections which interfered with our media campaign. While we were getting cards our people were involving themselves in two election campaigns: one federal and one provincial on behalf of various political parties.

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1 the approach that we had taken to this problem and while we
2 would like to see more cards, we think this is a very excellent
3 representation of the feeling of our people scattered throughout
4 the province in support of the things that we passed at our
5 convention. This is evidence of the feeling of the people in
6 that plan.

7 MR. WHITNEY: This gets to my next question.
8 Did you make a statistical compilation by geographic area as
9 to the number of cards returned?

10 MR. HAMILTON: No.

11 MR. WHITNEY: I notice Sarnia, the few that are
12 on the table here, Sarnia, Windsor.

13 MR. ARCHER: They were probably picked from
14 that area, in the bags there, as the area, and probably the
15 ones at the head table are all from the same area.

16 MR. HAMILTON: I think it is fair to say they
17 are widespread and they cover practically every city in the
18 province and every town in the province but we did not do a
19 calculation of how many from each town.

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2 it it would be good to have it on the record. In view
3 of the remarks of Mr. Archer, that medical services should
4 be made available, irrespective of how much money a man
5 makes or what he happens to own, how does that tie in
6 with the statement on your card, where you say "Paid for
7 according to ability to pay."? Would you explain this
8 statement. I am at a loss to know how those two things
9 jibe.

10 MR. ARCHER: The ability to pay, we
11 were thinking of in the form of taxation, such as you
12 would say the same thing about the old age pension. An
13 old age pensioner who had a pension could pay and that
14 they should get, I think at the time it was \$75 a month
15 at age 65, regardless of ability to pay. I think it is
16 used in that sense, without any means test.

17 MR. WHITNEY: I am not trying to put words
18 into your mouth. Can we say that what you mean here is
19 paid for out of government taxation, according to what
20 the government feels is the ability of the taxpayer to pay?

21 MR. ARCHER: Yes and no. I think it may
22 well have to be subsidized from taxes, but we see it as
23 a contributory scheme, sir, with contributions coming
24 from the individuals, much the same way as the Hospital
25 Services; but everyone being covered, regardless of his
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1 inability to pay, might be a better word than ability
2 to pay, I would think, in a strictly legal sense.

3 MR. WHITNEY: I do not think this other
4 question will take too long. We have already touched
5 on this area. It has just occurred to me that I am still
6 not in a settled state about it.

7 Whatever our recommendations are and
8 whatever the law is going to be, more particularly
9 with respect to our own recommendations, we realize
10 that there are a lot of varieties and very important
11 provisions in labour contracts with respect to medical
12 services, and we wouldn't want to make any recommendation
13 that would cause any difficulties, that we didn't
14 foresee. And we have to make calculated decisions here,
15 probably, or recommendations.

16 Is it going to cause -- if the present Bill,
17 with the general tone running through it now, which seems
18 to be government policy -- to a large extent, anyway,
19 we expect that it is government policy. There will
20 be recommendations and changes, undoubtedly, as a result
21 of recommendations. Do you see any serious rupture
22 of those agreements or difficulties in the agreements
23 if it goes along on a basis that the welfare group,
24 of course, is fully subsidized now. There may be another
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section of income earners with full subsidization. There

1 may be another layer above that with partial subsidization.
2 It would help me a lot if you could tell me what you
3 would think you might have to do with respect to the
4 contracts, if this sort of thing was in it?

5 MR. ARCHER: There will be certain dis-
6 locations, no matter whether you bring in a Bill that
7 satisfies us completely or that is completely opposed.
8 Any Bill is going to create certain dislocations. I
9 suppose it is the price we pay for progress. However,
10 we see a similarity between the Ontario Hospital Services
11 Commission, where the money that is now being paid for
12 private health schemes will be transferred to pay for
13 a government-sponsored health scheme and we do not
14 think there will be any great difficulty. Whatever small
15 difficulties there are will be made up for, in the long
16 run, by the desirability of the Medicare plan itself.

17 MR. SIMON: If I understand Mr. Whitney
18 correctly, what he says is assuming the Bill was not
19 changed and was accepted as it is, with some modifications,
20 does that affect the labour-managements agreements
21 on health insurance?

22 MR. ARCHER: I am not sure that it wouldn't.
23 I would have to see the regulations to give you an
24 informative statement on that.

25 MR. WHITNEY: We have them.
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1 MR. ARCHER: Yes.

2 MR. WHITNEY: If there is no serious area
3 of difficulty that you want to caution us about -- If any
4 of your experts, in making their studies, have pointed
5 out that there is a certain thing here that could be very
6 mechanically difficult for you, we would like to know
7 so we can keep our foot out of these traps.

8 MR. ARCHER: I can't see any, sir.

9 MR. WHITNEY: That is all I have, Mr.
10 Chairman. Thank you very much.

11 THE CHAIRMAN: I have a couple of questions.
12 In presenting the Medicare plan to your convention at
13 Niagara Falls, what is the procedure that leads up to
14 that presentation? I would assume that you have a
15 committee to study this. They come in with probably a
16 plan almost as it is here and present it to your convention?

17 MR. ARCHER: Yes.

18 THE CHAIRMAN: To what length was this
19 discussed? Was there considerable discussion about it
20 or was it almost taken very quickly in acceptance?

21 MR. ARCHER: No, sir. We couldn't do
22 anything at our convention like that. This one was
23 discussed practically the whole day. The microphones
24 were lined up -- 20 speakers at half a dozen microphones
25 waiting their turn to tell an executive of the Provincial
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waiting their turn to tell an executive of the provincial

1 Government, or anyone else who wanted to listen, how the
2 thing should be done. It was modified, a couple of
3 amendments here and there, and changes in language and
4 finally passed and then printed in its present form. The
5 usual way.

6 THE CHAIRMAN: Right from the beginning,
7 though, would it be correct to say that there was general
8 agreement with it, or was there fear expressed in some
9 parts about a universal medical plan?

10 MR. ARCHER: No. I think it would be fair
11 to say, sir, that the trade union movement has been on
12 record in favour of the principle of a universal medicare
13 plan and on that principle, there wasn't much difference.
14 The difference was on details.

15 THE CHAIRMAN: Actually, while this
16 happened in 1962, that is not the first time that the
17 trade union movement has been putting this forth?

18 MR. ARCHER: No.

19 THE CHAIRMAN: They have been playing this
20 tune for a good many years?

21 MR. ARCHER: I would think so. They
22 were probably presenting briefs to the government before
23 I was born. But, certainly as long as I have been in
24 the trade union movement, they have been demanding this
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1 THE CHAIRMAN: To what extent do you feel
2 that the average person in the union is knowledgeable
3 of what might be considered to be the pros as well as
4 cons in a universal medical care approach?

5 MR. ARCHER: It is a very difficult question,
6 as you know. I would think more so than the average
7 person on the street, because of the discussion that
8 has taken place, the literature he has received -- and
9 I realize that some of the literature might be called
10 propaganda, too. I am not trying to say anything
11 differently. But he has been intrigued by the question
12 of prepaid medicare and he has interested himself in it
13 and to the extent that the average person is interested
14 in any great, economic or social subject, I think our
15 people are probably more interested and probably more
2 16 knowledgeable than the average person in the community,
17 outside of the medical profession, perhaps, or somebody
18 who is directly involved.

19 THE CHAIRMAN: What led me to ask these
20 questions -- this is a very dramatic way, of course --
21 the way it reads here:

22 "I support Medicare... I support the
23 "O.F. of L. campaign to provide medicare
24 "for all with the highest quality services
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the way it reads here:

"I support Medicare. I support the
"O.F. of L. campaign to provide medicare
"for all with the highest quality services
"available, paid for according to ability

1 "to pay and without discrimination between
2 "rich and poor."

3 That is a pretty inviting thing to say
4 "Yes" to to anybody who might receive this in the mail,
5 without investigating to find out.

6 MR. HAMILTON: Would you sign one for
7 us, sir?

8 MR. ARCHER: We got some back from some
9 people with some unkind remarks. It wasn't quite that
10 simple.

11 THE CHAIRMAN: Any other questions?

12 MRS. AYLEN: On this subject of group
13 practice, on page 6 you say group practice should be
14 encouraged. Who are you suggesting should assist you?

15 MR. ARCHER: I would think the committees
16 and commissions that were set up to administer this
17 new medicare plan, whatever it might be, might give
18 assistance to the group practice.

19 MRS. AYLEN: Do you mean financial
20 assistance?

21 MR. ARCHER: I would think . . .

22 MRS. AYLEN: Or administrative?

23 MR. ARCHER: I wouldn't be particularly
24 opposed to financial assistance. I do not know what form
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opposed to financial assistance. I do not know what form
it would take.

1 MRS. AYLEN: Have we got this report of
2 the Toronto District Labour Council on a medical care
3 plan for Toronto?

4 MR. ARCHER: Have you got it?

5 MRS. AYLEN: Has that been sent out?

6 MR. ARCHER: We haven't. But we would
7 be glad to supply you with it. I do not know how much
8 material you want. I think it was Mr. Whitney -- if he
9 were interested in having a kit, we would be glad to
10 supply one to each and if you want the Toronto one, we
11 would supply that.

12 THE CHAIRMAN: I think if the Secretary
13 has one available for us, it will be all right.

14 MR. HAMILTON: It is in printed form and
15 we can make them available to each member of the Committee.

16 THE CHAIRMAN: How big is it?

17 MR. ARCHER: We will give you anything
18 you want. I do not know how much time you will get to
19 go through it all, but we will be glad to file it with
20 the Secretary. And if any member of the Committee feels
21 he or she would like a copy for his own personal file,
22 we would be glad to supply it.

23 MR. WHITNEY: I was under the impression
24 these were picked up by way of canvass.

25 MR. ARCHER: They were picked up in different
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MR. ARCHER: Have you got it?

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MRS. AYLEN: Have we got this report of

1 ways.

2 MR. WHITNEY: There are no stamps on these.

3 MR. ARCHER: Some of them are and some of
4 them aren't.

5 MR. HAMILTON: About two-thirds would have
6 stamps and the balance would have come in in bulk lots.

7 MR. ARCHER: Our local union would circulate
8 its membership and they would turn them into the
9 local union hall and they would be put in a parcel and
10 mailed into our office; so they would be mailed in, but
11 not stamps on each individual card.

12 MR. WHITNEY: There is three stamps on
13 this package.

14 MR. ARCHER: Yes. There are some that
15 sent them in.

16 MISS McARTHUR: On this last day of
17 hearings, Mr. Chairman, may I make a facetious remark?

18 THE CHAIRMAN: Yes.

19 MISS McARTHUR: On page 4, I was very
20 interested in . . .

21 MR. ARCHER: On which?

22 MISS McARTHUR: In your brief to this
23 Enquiry, I note that you have made several comments on
24 nursing and I find a common word coming up, in item
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1 nurse. I was wondering, what do you call me?

2 MR. HAMILTON: I imagine, while you are
3 on the Committee, a working nurse.

4 MISS McARTHUR: Thank you.

5 MR. ARCHER: You are working, but not at
6 nursing, I guess.

7 THE CHAIRMAN: Any further comments?

8 MR. CASWELL: I just wanted to ask Mr.
9 Archer a question. I assume that practically all members of
10 the Federation are today covered with at least a standard
11 medical plan, through your labour negotiations?

12 MR. ARCHER: I would think a great deal
13 of them are. I think it is a fair statement.

14 MR. CASWELL: So it would seem to me . . .

15 MR. ARCHER: . . . inadequate, in some
16 cases.

17 MR. CASWELL: . . . your greater concern
18 is for extended medical care?

19 MR. ARCHER: We like to say that the
20 trade union movement is acting in an unselfish manner
21 and it is more interested in those people outside of
22 the trade union movement who have no medical coverage than
23 it is actually for its own membership, in carrying on
24 this campaign. It is not quite that simple, but . . .

25 DR. GALLOWAY: I agree. I have read your
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24 this campaign. It is not quite that simple, but . . .
25 DR. GALLOWAY: I agree. I have read your

1 briefs on a number of occasions and they are certainly
2 very consistent and I know that you are particularly
3 interested in the health of the public, as you have just
4 stated, and there are so many aspects to it. One of
5 them is health insurance. You have never, so far as I
6 know, put down the other aspects: housing, clothing,
7 free education. Do you have any campaigns similar to
8 this that would further ensure the health of the public?

9 MR. ARCHER: We are now conducting a
10 campaign that I think probably would be ten times more
11 extensive than this on the question of portable pensions
12 and government pensions for our people.

13 We like to believe that we, almost single-
14 handed, were able to increase the old age pension by
15 our campaign when we deposited hundreds of thousands
16 of cards and petitions, and so on, on the government doorstep
17 in Ottawa, on Parliament Hill.

18 I could go on and on and on. I think
19 the trade union movement may be condemned or indicted for
20 a lot of things, but surely not on the question of
21 social progress -- fighting for the underdog, and so on,
22 mainly because we have been the underdog so much of the
23 time ourselves. There are a few people that are suggest-
24 ing we are not any more. I do not agree with that. But
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1 trade unions and the working man has not had what you
2 might call a square deal and the Union has fought. I
3 think we were the ones who fought on a committee like
4 this for workmen's compensation. The insurance companies
5 of the day, the private supporters of the day, wanted
6 private workmen's compensation and we fought them for
7 government coverage of workers hurt in industrial
8 accidents. Unemployment insurance . . .

9 DR. GALLOWAY: What are you doing about
10 these other aspects to show us the proper role of govern-
11 ment, like food and housing?

12 MR. ARCHER: Housing is our campaign for
13 this year. We are conducting almost the same campaign
14 this year on the question of adequate housing for the
15 people of Ontario as we did on this Medicare thing.
16 And, again, we would be glad to deposit with you, if it
17 is necessary, or with your Secretary, the kind of
18 campaign we are conducting now in the field of housing.

19 DR. GALLOWAY: These are also tax-supported
20 schemes?

21 MR. ARCHER: In many cases, yes, sir.

22 THE CHAIRMAN: Any further questions?

23 MR. MAJOR: Do I understand that Mr.
24 Archer was going to make arrangements for this extra
25 material to be sent to us, or do we have to ask for it, as
26

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trade unions and the working man has not had what you might call a square deal and the Union has fought. I think we were the ones who fought on a committee like this for workmen's compensation. The insurance companies of the day, the private supporters of the day, wanted private workmen's compensation and we fought them for government coverage of workers hurt in industrial accidents. Unemployment insurance . . .

DR. GALLOWAY: What are you doing about these other aspects to show us the proper role of government, like food and housing?

MR. ARCHER: Housing is our campaign for this year. We are conducting almost the same campaign this year on the question of adequate housing for the people of Ontario as we did on this Medicare thing. And, again, we would be glad to deposit with you, if it is necessary, or with your Secretary, the kind of campaign we are conducting now in the field of housing.

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Archer was going to make arrangements for this extra material to be sent to us, or do we have to ask for it, as

1 individuals?

2 THE CHAIRMAN: No. He is going to leave
3 a sample of it with the Secretary and then if we wish
4 additional copies, we can get them.

5 MR. ARCHER: We will do anything you want, if
6 the Chairman will instruct me on exactly what he wants.

7 THE CHAIRMAN: Is this satisfactory?

8 MR. MAJOR: Yes, that is fine. As soon
9 as the meeting is over, I will ask them to send me a
10 batch personally, so I will have it.

11 THE CHAIRMAN: I had intended to call a
12 recess at 4:30, but it seemed as though we were getting
13 so close to winding this hearing up that I delayed for
14 a little while. Are there any further comments?

15 MR. CASWELL: You did, Mr. Chairman, intend
16 to tell the gentlemen here what a worthy representative
17 they have on the Commission?

18 MR. ARCHER: No. Would you mind introducing
19 me to him, Mr. Caswell? No. I am being facetious.

20 May I say, in closing, that we thank you
21 very much for your very kind attention and your patience
22 with some of the meanderings that we get into sometimes
23 in this kind of discussion and we hope we have been of
24 some assistance to you.

25 If there is anything else we can do in any
26

individuals?

THE CHAIRMAN: No. He is going to leave

a sample of it with the Secretary and then if we wish

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May I say, in closing, that we thank you

some assistance to you.

If there is anything else we can do in any

1 way, simply have your Secretary get in touch with us and
2 we will be glad to co-operate in any manner we can.

3 Thank you, again.

4 THE CHAIRMAN: Thank you. We will have
5 a five-minute recess now.

6
7 ---A short recess.

1 THE CHAIRMAN: Thank you. We will have
2 a five-minute recess now.
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G/rps 1 THE CHAIRMAN: Will the delegates for the
2 College of Physicians and Surgeons of Ontario please come
3 forward. Do you wish to proceed then, Dr. Dawson?

4
5 SUBMISSION OF

6 THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

7 Appearances: Dr. J.W.R. Webster
8 Dr. J.C.C. Dawson

9 DR. DAWSON: Mr. Chairman, Dr. Webster,
10 the President of the College, and myself would like to
11 express to you the College's appreciation for inviting
12 us to this hearing this afternoon.

13 We've already submitted our brief to you,
14 which is pretty well limited to fact, and in a manner
15 of an opening statement I think the only thing that we
16 would like to say, sir, is that we have heard opinions
17 expressed from those representing various consumer groups
18 that they wish the people to have the very best quality
19 of health service available, and we feel that in order
20 to identify this quality of service to them, that there
21 should be no confusion in the use of the term physician,
22 and we have supported this in our brief with an outline
23 of the educational requirements, and the training for
24 the practitioner, and the training that the specialist
25 in medicine or surgery, or in any of its branches, is
26

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THE CHAIRMAN: Will the delegates for the

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DR. J.W.R. WEBSTER, M.D., F.R.C.P., F.R.S.

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of health service available, and we feel that in order

to identify this quality of service to them, that there

should be no confusion in the use of the term physician,

and we have supported this in our brief with an outline

of the educational requirements, and the training for

the practitioner, and the training that the specialist

in medicine or surgery, or in any of its branches, is

1 required to take, and we present to you, sir, that no
2 other group in the health services has had this degree
3 of training.

4 THE CHAIRMAN: Some of our members would
5 like to ask you questions. Mrs. Aylen?

6 MRS. AYLEN: Mr. Chairman, this is a very
7 good history of your organization, and I understand that
8 you have the authority to, what shall I say, police,
9 that's a rather strong word.

10 DR. DAWSON: Discipline, sir?

11 MRS. AYLEN: Discipline. That's a fair
12 word to use of this term, and what measures do you take
13 if it is used contrary to the ---

14 DR. DAWSON: Wherein a physician's conduct
15 has been complained of, the Executive Committee of the
16 College, which is a statutory body, reviews this, and
17 if they feel it is warranted, a charge of professional
18 misconduct is laid, and the doctor is summoned to appear
19 before the Judicial Committee, which is another
20 statutory body.

21 He can be represented by counsel, and witnesses
22 can be subpoenaed, and the decision of the Judicial
23 Subcommittee can be a dismissal of the charge, not guilty,
24 to a reprimand, or suspension of licence up to three
25 months.
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THE CHAIRMAN: Some of our members would

like to ask you questions. Mrs. Ayles?

Mrs. AYLES: Yes, Chairman, I have a few

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can be subpoenaed, and the decision of the Judicial

Subcommittee can be a dismissal of the charge, not guilty.

to a reprimand, or suspension of licence up to three

months.

1 The Chairman of the Discipline Committee,
2 acting for the Committee, may issue an admonishment to
3 the doctor.

4 If the Discipline Committee feels that
5 the offence is of a gravity to warrant a longer suspension,
6 they will make the recommendation to the Council, which
7 will then give its judgment, which can be permanent
8 erasure, or a period of suspension for longer than three
9 months, and once erased, that prohibits the medical
10 doctor from practising medicine.

11 MRS. AYLEN: That's dealing with physicians
12 in your own organization, but anybody outside?

13 DR. DAWSON: The College employs an
14 Inspector for this purpose, who is a retired R.C.M.P.
15 Sergeant, with a great deal of training in investigational
16 work.

17 It has to prove first of all that if
18 the complaint is that the individual is practising
19 medicine, the College has to prove that medicine has
20 been practised, and this has to stand up in court.

21 The College then, under the Section of
22 The Medical Act, will lay a charge against the individual,
23 which will be heard in the courts.

24 THE CHAIRMAN: Mr. Whitney?

25 MR. WHITNEY: I have no questions, Mr.
26

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The Chairman of the Discipline Committee,

and the Committee, was asked by the Chairman of

the doctor.

If the Discipline Committee feels that

the interests of the public are served by a longer suspension

they will make the recommendation to the Council, which

will then give its judgment, which can be permanent

or temporary, or a period of suspension for a longer term than

months, and once erased, that prohibits the medical

practice for a longer period.

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DR. DAWSON: The College employs an

Inspector for this purpose, who is a retired R.C.M.P.

physician, who is a member of the College and is responsible

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the complaint is that the individual is practicing

medicine, the College has to prove that medicine has

been practiced, and this has to stand up in court.

The College then, under the Section of

the Medical Act, has a power to suspend and investigate

which will be heard in the courts.

THE CHAIRMAN: Now, please

MR. WHITNEY: I have no questions, Mr.

1 Chairman.

2 THE CHAIRMAN: Mr. Naylor?

3 MR. NAYLOR: Actually I haven't any
4 questions either. I found the brief very clear and to
5 the point.

6 THE CHAIRMAN: Mr. Simon?

7 MR. SIMON: Mr. Chairman, there's one
8 question. On page 4 you say, in paragraph 9:

9 "To complete the assessment of the foreign
10 graduate's fitness to be licensed in Ontario
11 he must pass a screening test, take two
12 years of intern training in Ontario and
13 pass examinations in English ---".

14 What does this screening test mean to the
15 individual doctor? What does he have to do, and why
16 does it take two years of intern training in Ontario before
17 the College will grant him an Enabling Certificate to
18 write the examinations, when he may have had 20 years of
19 practice in Europe, in another country?

20 DR. DAWSON: Mr. Chairman, in answer to
21 Mr. Simon's question, the College is required under The
22 Medical Act to register only those who have had a pre-
23 medical and medical education equivalent to that provided
24 by medical schools in Ontario.

25 The first step is to satisfy, to be satisfied

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DR. DAWSON: Mr. Chairman, in answer to

Mr. Simon's question, the College is required under The
Medical Act to register only those who have had a pre-
medical and medical education equivalent to that provided
by medical schools in Ontario.

The first step is to satisfy, to be satisfied

1 that the individual is a graduate of a medical school
2 meeting these requirements. Since there are all grades
3 of graduates from any school, the College is anxious not
4 to register the inferior graduate from an outside school.

5 It also feels that the man who may not
6 have been engaged in the practice of medicine for five,
7 ten, or fifteen years in his own country, that there
8 should be some assessment to know whether he is a suitable
9 person to intern in one of our hospitals, and for those
10 purposes about three years ago the College adopted an
11 examination, conducted by the Educational College for
12 Foreign Medical Graduates. This is an organization that
13 was established in the United States by the American
14 Hospital Association, the American Association of Medical
15 Colleges, the American Medical Association, and the
16 National Board of Medical Examiners, and they have
17 established an examination which is now conducted twice
18 a year at a hundred and some odd stations around the
19 world at the same time, where the graduates of foreign
20 medical schools who were graduates of schools recognized
21 by the World Health Organization, and have completed
22 the requirement of 18 years of medical and university
23 education, are examined in English and the clinical
24 subjects.

25 Those that pass this examination are granted
26

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Those that pass this examination are granted

1 what is called the E.C.F.M.G. certificate, and this
2 assures us that they are suitable people to intern in
3 one of our hospitals. This is now a requirement for
4 registration on the College's Intern Register, or
5 Educational Register.

6 It's very interesting to note that in the
7 Basic Science examinations before the E.C.F.M.G. exam-
8 inations were required we had very high failure rates
9 for foreign graduates. It was almost an imposition to
10 ask our examiners to spend time examining any of these
11 foreign graduates. Their English and knowledge of the
12 basic science subjects was poor, but having come through
13 this screening test, we are now getting a pass rate of
14 80 to 85%, compared to 40 to 50% before the screening
15 test.

16 MR. SIMON: Don't you feel that two years
17 of internship is too rigid for some doctors?

18 We realize that we would like to have all
19 the doctors pass the examination, and be suitable for
20 practice, but on the other hand I don't think we should
21 be interested in keeping doctors out who would be able
22 to practise here after being here six months.

23 DR. DAWSON: The purpose of the intern-
24 ship is a multi-purpose arrangement, or regulation, and
25 in the first place these doctors have come to Ontario, or
26

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20 be interested in keeping doctors out who would be able
21 to practice here after being here six months.
22 DR. DAWSON: The purpose of the intern-
23 ship is a multi-purpose arrangement, or regulation, and
24 in the first place these doctors have come to Ontario, or

1 | come to Canada, from areas where the practice of medicine
2 | is somewhat different. Their training has been different,
3 | and their use of drugs has been different. The drugs even
4 | have different names.

5 | We're all familiar with the controversial
2 6 | discussions going on on the use of generic names versus
7 | the patented, or registered names, and this is one of the
8 | problems and one of the very important values of this
9 | long intern training of the two-year period, is that it
10 | gives the qualified, responsible people, heading up
11 | hospital departments an opportunity to assess the skill,
12 | judgment, and knowledge of these interns, and each year
13 | the College has found that it has to turn down -- the
14 | reports that it receives -- it receives a confidential
15 | report from the Heads of the major departments on the
16 | interns, and it turns the intern back to repeat his intern-
17 | ship because of the reports that we are given on his
18 | performance.

19 | THE CHAIRMAN: What salary would such an
20 | intern receive? In other words, a doctor coming over
21 | here, would he be able to live during those two years on
22 | what he might receive in the way of compensation?

23 | DR. DAWSON: I think he gets in the neighbour-
24 | hood of \$200 a month, Mr. Chairman. Now, that's a quick,
25 | off-the-cuff figure, plus his board and room.

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hood of \$200 a month, Mr. Chairman. Now, that's a quick,

off-the-cuff figure, plus his board and room.

1 Now, in his second and third year he will
2 get more. I think possibly one or two members of your
3 Enquiry could help you on that.

4 THE CHAIRMAN: You mentioned an inferior
5 graduate from another, foreign university. Do you mean
6 by that that a student who has graduated from a university
7 that you recognize as offering a program that is basically
8 the equivalent of the education that a medical student
9 would receive in Ontario, if he graduates you might still
10 consider him to be an inferior graduate, and is this
11 decision made before he tries these examinations, or on
12 the basis of the examinations?

13 DR. DAWSON: Well Mr. Chairman, if his
14 knowledge of English is adequate he should not have
15 difficulty with the E.C.F.M.G. examination, and this
16 will screen out the greater number of the poorer graduates
17 from the foreign schools.

18 He comes into Ontario, commences his
19 internship, and then we start getting reports on the
20 quality of his knowledge. He has his basic science
21 examinations ---

22 THE CHAIRMAN: It's on the basis of
23 these examinations and reports, rather than that the
24 graduate might have had 70%, and you might accept another
25 one on the basis of 60%?
26

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get more. I think possibly one or two members of your

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study of his knowledge. He has his basic science

examinations ---

THE CHAIRMAN: It's on the basis of

these examinations and reports, rather than that the

graduate might have had 70%, and you might accept another

one on the basis of 60%?

1 DR. DAWSON: No, we would say that there
2 would be good graduates and poor graduates from the
3 approved schools.

4 THE CHAIRMAN: But you do have the
5 same situation in our own schools.

6 DR. GALLOWAY: Dr. Dawson, have you yet
7 completed your list, or can you tell us how many licensed
8 practitioners there are in Ontario; and secondly, can
9 you tell us whether they are practising?

10 Can you tell us the number of specialists
11 that you have referred to in paragraph 6?

12 DR. DAWSON: Mr. Chairman, in reply to
13 Dr. Galloway's questions, we haven't the figure for the
14 end of January yet, but it will be in the neighbourhood
15 of nine thousand three or four hundred on the Register
16 of the College.

17 These doctors aren't all resident in Ontario.
18 I would think there would be somewhere between eight
19 thousand and eight thousand four hundred of those registered
20 residing in Ontario.

21 We can't break this down to those who
22 are actively engaged in practice, and those who aren't,
23 because we have one doctor who is presently fully
24 registered for this year, and her fees paid, and she
25 will have her hundredth birthday in October of this year,
26

DR. DAWSON: No, we would say that there

is no such thing as a general practitioner in the

profession.

THE CHAIRMAN: But you do have the

same situation in our own schools.

DR. GALLOWAY: Dr. Dawson, have you yet

completed your list, or can you tell us how many licensed

practitioners there are in Ontario; and secondly, can

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I would think there would be somewhere between eight

thousand and eight thousand four hundred of those registered

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We can't break this down to those who

are actually practising in Ontario, and those who are not.

There is no doubt that it is practically impossible

registered for this year, and her fees paid, and she

will have her hundredth birthday in October of this year.

1 and I don't think she is practising medicine.

2 There are a number of people who, for
3 emotional or sentimental reasons, ~~keep up~~ their membership.

4 THE CHAIRMAN: She must have been a good
5 doctor.

6 DR. DAWSON: Yes. As regards the
7 specialists, the same remarks would apply as far as
8 those registered in Ontario, but there are 2,800 special-
9 ists on the register.

10 DR. GALLOWAY: Licensed?

11 DR. DAWSON: Yes.

12 DR. GALLOWAY: Can you make any estimate
13 at all of the number practising?

14 DR. DAWSON: No. We have no way of
15 determining this, Mr. Chairman.

16 DR. GALLOWAY: Have you broken them down
17 in anyway to districts?

18 DR. DAWSON: Just a year ago at this
19 time, through assistance from the Minister of Health
20 of Ontario, the College did a survey that I.B.M. ran off
21 for it, and ~~this~~ ~~is~~ listed by specialties and general practice
22 doctors, in all communities of Ontario of 5,000 and
23 over, and also by counties.

24 A copy of this material is ~~st~~ill available,
25 if it would be of any interest to you, sir.

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There are a number of people who, for

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DR. DAWSON: Yes. As regards the

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DR. GALLOWAY: Is that right?

DR. DAWSON: Yes.

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first time in the history of the profession that a survey was

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if it would be of any interest to you, sir.

1 THE CHAIRMAN: If you have it, you might
2 send it to the Secretary, and it would be helpful.

3 DR. GALLOWAY: The only other question I
4 have, Dr. Dawson, you may not be able to answer.

5 Do you know at present the relationship of
6 doctors to individuals in the province? Can you give
7 us a doctor/patient relationship, in other words the number
8 of doctors against the number of potential patients?

9 DR. DAWSON: We have on this survey I'm
10 referring to, we have the doctor/patient relationship
11 for each of these communities.

12 DR. GALLOWAY: This would be useful. Have
13 you been able to make any estimate as to how long in the
14 present trend in immigration and education the population
15 growth will exist?

16 DR. DAWSON: Well, I would think, Mr.
17 Chairman, that the sooner the new medical school, or
18 schools, is established in Ontario, the better if we
19 hope to maintain this ratio.

20 DR. GALLOWAY: You can't make any
21 estimate if there isn't a new medical school?

22 DR. DAWSON: No, I hate to contemplate
23 that, sir.

24 THE CHAIRMAN: The shortage of space is,
25 however, a deterrent?
26

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that.

THE CHAIRMAN: The shortage of space is,

however, a deterrent?

1 DR. DAWSON: The places in the medical
2 schools?

3 THE CHAIRMAN: Yes?

4 DR. DAWSON: Yes, this is correct sir.

5 DR. GALLOWAY: These aren't idle questions,
6 Dr. Dawson, but related to the fact that we are going to
7 try and develop something, and it's a matter of utilization,
8 and I'm thinking if the trend shows that there will be
9 an increase in the utilization of services, if we will
10 have a decreasing number of doctors in relation to the
11 increasing population, we should know something about it.

12 DR. DAWSON: Well, we haven't attempted,
13 Mr. Chairman, to do any survey in depth on this aspect.

14 THE CHAIRMAN: Is this more in the field
15 of the O.M.A. than the College?

16 DR. DAWSON: I think it is more in the
17 field of the Ontario Medical Association.

18 MR. SIMON: In paragraph 12, on page 5,
19 you make reference to Bill 163, " ---that the insured
20 services are to be rendered by, or under the direction
21 of a physician, ---" and then you go on to spell out the
22 term physician, and so on, and in paragraph 14, on the
23 following page, you suggest that:

24 "The College of Physicians and Surgeons

25 "of Ontario strongly advocates that no one
26

DR. DAWSON: The places in the medical

THE CHAIRMAN: Yes?

DR. DAWSON: Yes, this is correct sir.

DR. GALLOWAY: These aren't idle questions,

Dr. Dawson, but related to the fact that we are going to

try and develop something, and it's a matter of utilization,

and I'm thinking if the trend shows that there will be

an increase in the utilization of services, if we will

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MR. SIMON: In paragraph 12, on page 2,

you make reference to Bill 103, "---that the insured

services are to be rendered by, or under the direction

of a physician, ---" and then you go on to spell out the

term physician, and so on, and in paragraph 14, on the

following page, you suggest that:

"The College of Physicians and Surgeons

"of Ontario strongly advocates that no one

1 "should be represented to the public as
2 "a 'Physician' who has not fulfilled the
3 "lengthy and rigorous education and
4 "training required for registration under
5 "the Medical Act as set out above."

6 Now, this is true, and I'm 'sure it's
7 true with regards to physicians and medical service,
8 but what about the demand for greater service by the
9 public, for related health care?

10 DR. DAWSON: I'm sorry, Mr. Simon.

3 11 MR. SIMON: For related health care. We
12 have had representations here by different professions
13 who are now giving service to the public. We had one
14 here this morning, or this afternoon, the osteopaths.

15 With the specialization of medicine, and
16 so on, would you consider that the public would not be
17 served as well by some of these related professions in
18 these specialized fields, just as well as by physicians?

19 DR. DAWSON: Mr. Chairman, I must give
20 a very short and brief answer to that, and my answer is
21 no.

22 Now, the one point that I would just
23 wish to direct Mr. Simon's attention to, is paragraph 13,
24 that it is not the intention of the College to suggest
25 to the Enquiry who should provide the services, but that
26

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1 where the word physician is used that this term should be
2 restricted, as it is at present, to those registered
3 under The Medical Act.

4 MR. SIMON: Well, we could easily call
5 it health care, or something else instead of physician's
6 care.

7 DR. DAWSON: Yes, but we're not debating
8 that point.

FB/rps 9 MR. SIMON: You are not suggesting it
10 will be restricted to physicians?

11 DR. DAWSON: We didn't deal with this.
12 We saw our purpose in presenting the brief in the
13 reference to the term "physician".

14 THE CHAIRMAN: Mr. Coulter?

15 MR. COULTER: I think it was stated, you
16 mentioned there was a shortage of teaching space which
17 was some cause of a shortage of doctors. I was wondering
18 how many students a year would be turned away on account
19 of this.

20 DR. DAWSON: I think that approximately
21 seventy were turned away in Ontario in December due to
22 lack of facilities. There may have been room in another
23 medical school in Ontario or in Canada but for economic
24 reasons, for family reasons, one reason or another very
25 very few of the students went on into medicine.

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1 MR. COULTER: You haven't any figures
2 of how many were turned away in Canada from all medical
3 schools?

4 DR. DAWSON: No, we haven't that figure.

5 MR. COULTER: Would this figure be avail-
6 able, I wonder?

7 DR. DAWSON: I think this could be obtained
8 by corresponding with the deans. There are twelve
9 medical schools in all of Canada. This figure could be
10 obtained. It is very interesting that the number of
11 students enrolling each year in medicine has been increas-
12 ing over the last four years. There was a downward
13 trend before that, and a downward trend in the United
14 States. The trend in Canada started up about a year and
15 a half before it started up in the United States.

16 MR. COULTER: Thank you. That is all
17 I have.

18 THE CHAIRMAN: Mr. Whitney?

19 MR. WHITNEY: One short question that
20 doesn't arise out of the brief. Schedule A starts
21 up talking about physicians. If we were to say physician
22 and surgeon at the top of Schedule A instead of the
23 word "physician", would this cause consequences?

24 DR. DAWSON: Well, we have only dealt
25 in our brief, Mr. Chairman, with the term physician, but
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up talking about physicians. If we were to say physician

and surgeon at the top of Schedule A instead of the

word "physician", would this cause consequences?

DR. DAWSON: Well, we have only dealt

in our brief, Mr. Chairman, with the term physician, but

1 we would have added the phrase physician and surgeon just
2 as readily. One exception, and that is also referred to
3 in the brief, that those licensed in The Dentistry Act
4 have the privilege of using the term "surgeon".

5 MR. WHITNEY: That is the only exception?

6 DR. DAWSON: It is the exception and it
7 is an exception included in the provisions of The Medical
8 Act.

9 MR. WHITNEY: If we did put the word
10 "surgeon" in there then we would really be taking in the
11 oral surgeons then, I see.

12 THE CHAIRMAN: It would only be one group
13 of the oral surgeons.

14 DR. DAWSON: You would take in the dental
15 surgeons, what we commonly refer to as dentists.

16 MR. WHITNEY: There wouldn't be anyone
17 else coming in under the word surgeon, would there?

18 DR. DAWSON: No.

19 MR. CASWELL: Couldn't you leave out
20 surgeon?

21 DR. GALLOWAY: The word physician as
22 commonly used in its broadest sense is any man in
23 medicine. He becomes a physician primarily and from
24 there he also is a physician, obstetrician and surgeon.
25 He is primarily a physician and surgeon. The term physician
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He is primarily a physician and surgeon. The term physician

1 is all-inclusive for these fields. I think that is what
2 it is.

3 DR. DAWSON: Yes.

4 THE CHAIRMAN: Any further questions?

5 MR. MAJOR: Yes, I have a couple of questions.

6 You added the word surgeon to this. A veterinary surgeon
7 would be eligible.

8 DR. DAWSON: Veterinarians practise under
9 their own Act and their services are limited -- they are
10 not licensed to practise.

11 MR. MAJOR: Dr. Dawson, can a university
12 practise medicine?

13 DR. DAWSON: Only when licensed by the
14 College it can practise medicine, but only the individual
15 can be licensed.

16 MR. MAJOR: You don't licence a corporation
17 or an institution or an association and this precludes
18 the possibility of a hospital practising medicine; is
19 that correct?

20 DR. DAWSON: There is somebody I would
21 like to be sitting here, and that is our solicitor.

22 MR. MAJOR: Outside of your solicitor I
23 can't think of anybody who knows more about medical
24 jurisprudence than you do.

25 THE CHAIRMAN: I think this was discussed
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1 when we had the brief from the Ontario Medical Association
2 and they gave an answer.

3 MR. MAJOR: They gave an answer, but I am
4 asking the College of Physicians and Surgeons.

5 DR. DAWSON: There is a case on record
6 where Mr. Justice McLennan in his judgment stated it was
7 only an individual who was licensed to practise medicine.

8 MR. WHITNEY: That is the practice of the
9 law profession and also the accountancy profession. We
10 are not allowed to incorporate. We must be individually
11 licensed. I think accountants are allowing incorporating,
12 but I am not sure about that. A corporation can't practise
13 a profession.

14 MR. MAJOR: Dr. Dawson, are you acquainted
15 with the brief that was presented by the Universities
16 wherein they are setting forth the proposition of setting
17 up in-patient and out-patient clinics and the doctors
18 could collect fees for these services the same as a
19 doctor in private practice. These clinics would be establish-
20 ed within the realm of and under the "control", I will
21 put control in quotes, I am not sure, of a hospital.

22 In your opinion would there be any room
23 here for dispute or discussions or would this hospital
24 or would the medical people get into difficulty over this
25 as time went on or would you be prepared in the interests
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1 of the Enquiry to take this document and give us your
2 opinion on it as to where it sits in the Medical Act and
3 how an association might be in the setup with respect
4 to the practice of medicine?

5 DR. DAWSON: Yes, Mr. Chairman, I would
6 be very glad to offer any assistance that I can. I'm
7 saying this personally and any opinion would be my personal
8 opinion. At the same time I am sure the Executive
9 Committee of the College would be pleased to review for
10 you any documents. I may say from what I know of the
11 situation, Mr. Major, I think likely the arrangement
12 will be arrived at where the physician is practising
13 medicine and being remunerated for his service and the
14 hospital, university or other institution is providing
15 the space and facilities.

16 MR. MAJOR: Dr. Dawson, I am quite sure
17 this Enquiry doesn't want to interfere with the citizen's
18 freedom of choice. We wouldn't want to make any
19 recommendations or we wouldn't want to make any statement
20 or even an inference that would fall outside this sphere
21 of the proper legal setup of this and we might have to
22 ask for help from your College in this case. There is
23 another area that has been rather confusing, if not to
24 the other members, certainly to myself, and that is the
25 responsibility of professions.

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another area that has been rather controversial in the
other members, certainly to myself, and that is the
responsibility of professions.

1 I don't know exactly how to put this to
2 you. My idea is something like this: I have always
3 felt that the average man in the practice of medicine
4 has certain responsibility and that if he is guilty of
5 not doing reasonably good practice he can be chastized
6 for it by some organized body, even down to the legal
7 setup. Is this true?

8 DR. DAWSON: Yes, this is true, Mr.
9 Chairman.

10 MR. MAJOR: From your knowledge, and maybe
11 we are ultra vires, but let us take optometry as a sample
12 of allied professions, if you want to refer to them in
13 that way, in your dealings with things from a medical
14 jurisprudence standpoint, would you say that this is
15 true of allied professions, they are under the same
16 legal responsibility.

17 DR. DAWSON: I am not that familiar with
18 many of them. I would say many of them are.

19 MR. MAJOR: Do you think the public is
20 well protected?

21 DR. DAWSON: From some of them they
22 have some protection. They certainly have in the dental
23 profession and they have from the nursing profession.

24 MR. MAJOR: That you, that is all I
25 have, Mr. Chairman. It is true of the nursing profession?
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1 DR. DAWSON: I believe so, the College
2 of Nursing now have an Act with authority.

3 MR. MAJOR: Have you ever had a case of
4 a nurse being sued for malpractice?

5 DR. DAWSON: Sued for damages, yes.

6 MR. MAJOR: Thank you.

7 THE CHAIRMAN: Any further questions?
8 Do you have any further statement you would like to make?

9 DR. DAWSON: Nothing further except to
10 thank you for the opportunity of making the submission.

11 THE CHAIRMAN: Thank you. We may be
12 calling upon you.

13
14 ---Adjournment.

15
16 * * * * *

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24 MR. MAJOR: Thank you very much, I am
25 now, Mr. Chairman, I am sure of the nursing profession?
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